CHAPTER 13 – NC MEDICAL CARE COMMISSION

SUBCHAPTER 13A – EXECUTIVE COMMITTEE

SECTION .0100 – EXECUTIVE COMMITTEE

10A NCAC 13A .0101 EXECUTIVE COMMITTEE

(a) There shall be an executive committee of the North Carolina Medical Care Commission composed of five members of the commission in addition to the chairman and vice-chairman of the commission. Three members shall be appointed by a vote of the commission at the December meeting of each odd year and two members shall be appointed by the chairman of the commission at the December meeting of each even year. No member of the executive committee, except the chairman and vice-chairman, shall serve more than two two-year terms in succession. The chairman and vice-chairman of the commission shall also be chairman and vice-chairman of the executive committee.

(b) The functions of the executive committee shall be to:

(1) transact business in behalf of the commission, consistent with established policy, which in the opinion of the chairman is of such urgency that action is required before the next regularly scheduled commission meeting and the impact of the action would not justify the convening of a special meeting of the commission;

(2) transact business in behalf of the commission when a quorum is not obtained at any commission meeting for which prior notice of at least ten days has been given;

(3) review periodically the activities of the commission and the assignments and recommendations of the various committees for the purpose of developing policy recommendations for commission consideration.

(c) All actions of the executive committee shall be reviewed at the next commission meeting and if disagreement is expressed by a simple majority of the members present and voting at any commission meeting in which a quorum is present, the functions of the executive committee shall be suspended until resolved by later action of the commission.

(d) The initial approval of all projects under the Health Care Facilities Finance Act must be given by a quorum of the full commission.

(e) A quorum of the executive committee shall consist of at least four members of the executive committee.

History Note: *Authority G.S. 131A-4; 143B-165; 143B-166;*
Eff. January 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

SECTION .0200 - RULEMAKING

10A NCAC 13A .0201 PETITIONS

(a) Any person wishing to submit a petition requesting the adoption, amendment, or repeal of a rule or rules by the North Carolina Medical Care Commission shall submit the petition addressed to: Office of the Director, Division of Health Service Regulation, 2701 Mail Service Center, Raleigh, North Carolina, 27699-2701.

(b) The petition shall contain the following information:

(1) the text of the proposed rule or rules for adoption or amendment, the rule number of the proposed rule or rules for repeal, and the statutory authority for the agency to promulgate the rule or rules;

(2) a statement of the effect on existing rules;

(3) a statement of the effect of the proposed rule or rules on existing practices in the area involved, if known; and

(4) the name(s) and address(es) of petitioner(s).

(c) The petitioner may include the following information within the request:

(1) documents and any data supporting the petition;

(2) a statement of the reasons for adoption of the proposed rule or rules, amendment or the repeal of an existing rule or rules;

(3) a statement explaining the costs and computation of the cost factors, if known; and

(4) a description, including the names and addresses, if known, of those individuals or entities most likely to be affected by the proposed rule or rules.

(d) The North Carolina Medical Care Commission, based on a review of the facts stated in the petition, shall consider the following in the determination to grant the petition:

(1) whether the North Carolina Medical Care Commission has authority to adopt the rule or rules;
(2) the effect of the proposed rule(s) on existing rules, programs, and practices;
(3) probable costs and cost factors of the proposed rule or rules;
(4) the impact of the rule on the public and the regulated entities; and
(5) whether the public interest will be served by granting the petition.

(e) Petitions that do not contain the information required by Paragraph (b) of this Rule shall be returned to the petitioner by the Chairman of the North Carolina Medical Care Commission.

History Note: *Authority G.S. 143B-165; 150B-20;*
Eff. February 1, 1976;
Readopted Eff. December 19, 1977;
Amended Eff. November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015;
Amended Eff. October 1, 2023.

10A NCAC 13A .0202 RULEMAKING PROCEDURES

(a) The rulemaking procedures for the Secretary of the Department of Health and Human Services codified in 10A NCAC 01 are hereby adopted by reference pursuant to G.S. 150B-14(c) to apply to the actions of the Commission, with the following modifications:

(1) Correspondence related to the Commission's rulemaking actions shall be submitted to:

APA/Rule-making Coordinator
Office of the Director
Division of Health Service Regulation
2701 Mail Service Center
Raleigh, North Carolina 27699-2701

(2) The Secretary's designee shall mean the Director of the Division of Health Service Regulation (hereinafter referred to as the Division).
(3) The "Division" shall be substituted for the "Office of General Counsel" in 10A NCAC 01.
(4) "Hearing officer" shall mean the Chairman of the Medical Care Commission or his designee.

(b) Copies of 10A NCAC 01 may be inspected in the Division at the address shown in (a)(1) of this Rule. Copies may be obtained from the Office of Administrative Hearings, 424 North Blount Street, Raleigh, North Carolina, 27601.

History Note: *Authority G.S. 143B-165; 150B-11; 150B-14;*
Eff. November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13A .0203 DECLARATORY RULINGS

(a) The Commission shall have the power to make declaratory rulings. All requests for declaratory rulings shall be written and submitted to: Chairman, Medical Care Commission, 2701 Mail Service Center, Raleigh, North Carolina, 27699-2701.

(b) All requests for a declaratory ruling must include the following information:

(1) name and address of the petitioner;
(2) statute or rule to which petition relates;
(3) concise statement of the manner in which petitioner is aggrieved by the rule or statute or its potential application to him;
(4) the consequences of a failure to issue a declaratory ruling.

(c) Whenever the Commission believes for good cause that the issuance of a declaratory ruling will not serve the public interest, it may refuse to issue one. When good cause is deemed to exist, the Commission will notify the petitioner of the decision in writing stating reasons for the denial of a declaratory ruling.
(d) The Commission may refuse to consider the validity of a rule and therefore refuse to issue a declaratory ruling:

(1) unless the petitioner shows that the circumstances are so changed since adoption of the rule that such a ruling would be warranted;
(2) unless the rulemaking record evidences a failure by the agency to consider specified relevant factors;
(3) if there has been similar controlling factual determination in a contested case, or if the factual context being raised for a declaratory ruling was specifically considered upon adoption of the rule being questioned as evidence by the rulemaking record;
(4) if circumstances stated in the request or otherwise known to the agency show that a contested case hearing would presently be appropriate.

(e) Where a declaratory ruling is deemed to be in the public interest, the Commission will issue the ruling within 60 days of receipt of the petition.
(f) A declaratory ruling procedure may consist of written submissions, oral hearings, or such other procedure as may be appropriate in a particular case.
(g) The Commission may issue notice to persons who might be affected by the ruling that written comments may be submitted or oral presentations received at a scheduled hearing.
(h) A record of all declaratory ruling procedures will be maintained for as long as the ruling has validity. This record will contain:

(1) the original request,
(2) reasons for refusing to issue a ruling,
(3) all written memoranda and information submitted,
(4) any written minutes or audio tape or other record of the oral hearing, and
(5) a statement of the ruling.

This record will be maintained in a file at the Director's office at Division of Health Service Regulation, 2701 Mail Service Center, Raleigh, North Carolina, 27699-2701 and will be available for public inspection during regular office hours.

History Note: *Authority G.S. 143B-165; 150B-4;*
Eff. November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

SUBCHAPTER 13B – LICENSING OF HOSPITALS

10A NCAC 13B .0100 RESERVED FOR FUTURE CODIFICATION

SECTION .0200 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .0200 RESERVED FOR FUTURE CODIFICATION

SECTION .0300 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .0300 RESERVED FOR FUTURE CODIFICATION

SECTION .0400 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .0400 RESERVED FOR FUTURE CODIFICATION

SECTION .0500 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .0500 RESERVED FOR FUTURE CODIFICATION

SECTION .0600 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .0600 RESERVED FOR FUTURE CODIFICATION

SECTION .0700 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .0700 RESERVED FOR FUTURE CODIFICATION

SECTION .0800 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .0800 RESERVED FOR FUTURE CODIFICATION

SECTION .0900 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .0900 RESERVED FOR FUTURE CODIFICATION

SECTION .1000 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .1000 RESERVED FOR FUTURE CODIFICATION

SECTION .1100 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .1100 RESERVED FOR FUTURE CODIFICATION

SECTION .1200 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .1200 RESERVED FOR FUTURE CODIFICATION

SECTION .1300 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .1300 RESERVED FOR FUTURE CODIFICATION

SECTION .1400 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .1400 RESERVED FOR FUTURE CODIFICATION

SECTION .1500 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .1500 RESERVED FOR FUTURE CODIFICATION

SECTION .1600 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .1600 RESERVED FOR FUTURE CODIFICATION

SECTION .1700 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .1700 RESERVED FOR FUTURE CODIFICATION

SECTION .1800 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .1800 RESERVED FOR FUTURE CODIFICATION

SECTION .1900 - SUPPLEMENTAL RULES FOR THE LICENSURE OF THE SKILLED: INTERMEDIATE: ADULT CARE HOME BEDS IN A HOSPITAL

10A NCAC 13B .1901 SUPPLEMENTAL RULES

When a hospital offers nursing facility or adult care home long-term care services, the services shall be included under one hospital license as provided in Rule .0201(c). The general requirements included in this Subchapter shall apply when applicable but in addition the nursing facility care and adult care home care unit must meet the supplemental requirements of this Section.

History Note: Authority G.S. 131E-79; 42 U.S.C. 1396 r (a);
Eff. February 1, 1986;
Temporary Amendment Eff. October 1, 1990 For a Period of 142 Days to Expire on February 28, 1991;
Amended Eff. March 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1902 DEFINITIONS

The following definitions shall apply throughout this Section, unless text otherwise indicates to the contrary:

(1) "Accident" means something occurring by chance or without intention that has caused physical or mental harm to a patient, resident, or employee.
(2) "Administer" means as defined in G.S. 90-87.
(3) "Administrator" means the person who has authority for and is responsible to the governing board for the overall operation of a facility.
(4) "Brain injury long-term care" is defined as an interdisciplinary, intensive maintenance program for patients who have incurred brain damage caused by external physical trauma and who have completed a primary course of rehabilitative treatment and have reached a point of no gain or progress for more than three consecutive months. Services are provided through a medically supervised interdisciplinary process and are directed toward maintaining the individual at the optimal level of physical, cognitive, and behavioral functioning.
(5) "Combination Facility" means any hospital with nursing home beds that is licensed to provide more than one level of care such as a combination of intermediate care and skilled nursing care and adult care home care.
(6) "Department" means the North Carolina Department of Health and Human Services.
(7) "Director of Nursing" means the nurse who has authority and responsibility for all nursing services and nursing care.
(8) "Dispense" means as defined in G.S. 90-87.
(9) "Drug" means as defined in G.S. 90-87.
(10) "Duly Licensed" means holding a current and valid license as required under the General Statues of North Carolina.
(11) "Incident" means an intentional or unintentional action, occurrence or happening that is likely to cause or lead to physical or mental harm to a patient, resident, or employee.
(12) "Licensed Practical Nurse" means as defined in G.S. 90-171.30 or G.S. 90-171.32.
(13) "Medication" means "drug" as defined in Item (9) of this Rule.
(14) "Nurse Aide" means any individual providing nursing or nursing-related services to patients in a facility, and is not a licensed health professional, a qualified dietitian or someone who volunteers to provide such services without pay, and who is listed in a Nurse Aide Registry pursuant to G.S. 131E-255.
(15) "Nurse Aide Trainee" means an individual who has not completed an approved nurse aide training course by the Department in accordance with 10A NCAC 13O .0301, herein incorporated by reference including subsequent amendments and editions, and competency evaluation and is demonstrating knowledge, while performing tasks that they have been found proficient in by an instructor. These tasks shall be performed under the supervision of a registered nurse. The term does not apply to volunteers.
(16) "Nursing Facility" means that portion of a nursing home certified under Title XIX of the Social Security Act (Medicaid) as in compliance with federal program standards for nursing facilities. It is often used synonymous with the term "nursing home," the usual prerequisite level for state licensure for nursing facility (NF) certification and Medicare skilled nursing facility (SNF) certification.

(17) "Nurse in Charge" means the nurse to whom duties for a specified number of patients and staff for a specified period of time have been delegated, such as for Unit A on the 7-3 or 3-11 shift.
(18) "On Duty" means personnel who are awake, dressed, and responsive to patient needs and present in the facility performing assigned duties.
(19) "Patient" means any person admitted for care to a skilled nursing or intermediate care facility.
(20) "Physician" means as defined in G.S. 90-9.1 or G.S. 90-9.2.
(21) "Qualified Dietitian" means as defined in 42 CFR 483.60(a)(1), herein incorporated by reference including subsequent amendments and editions. Electronic copies of 42 CFR 483.60 can be obtained free of charge at https://www.ecfr.gov/cgi-bin/text-idx?SID=1260800a39929487f0ca55b0ab5e710b&mc=true&tpl=/ecfrbrowse/Title42/42cfrv5_02.tpl#0.
(22) "Registered Nurse" means as defined in G.S. 90, Article 9A.
(23) "Resident" means as defined in G.S.131D-2.1.
(24) "Supervisor-in-Charge" means a duly licensed nurse to whom supervisory duties have been delegated by the Director of Nursing.
(25) "Ventilator dependence" means physiological dependency by a patient on the use of a ventilator for more than eight hours a day.

History Note: *Authority G.S. 131E-79;*
Eff. February 1, 1986;
Amended Eff. March 1, 1990;
Temporary Amendment Eff. October 1, 1990 For a Period of 142 Days to Expire on February 28, 1991;
Amended Eff. February 1, 1993; December 1, 1991; March 1, 1991;
Readopted Eff. April 1, 2020.

10A NCAC 13B .1903 INSPECTIONS

(a) Any hospital with beds licensed by the Department under Section .1900 of these Rules may be inspected by one or more authorized representatives of the Department at any time. Generally, inspections will be conducted between the hours of 8:00 a.m. and 6:00 p.m., Monday through Friday. However, complaint investigations shall be conducted at the most appropriate time for investigating allegations of the complaint.
(b) At the time of inspection, any authorized representative of the Department shall make his presence known to the administrator or other person in charge who shall cooperate with such representative and facilitate the inspection.

History Note: *Authority G.S. 131E-79; 42 U.S.C. 1396 r (a);*
Eff. February 1, 1986;
Amended Eff. March 1, 1990;
Temporary Amendment Eff. October 1, 1990 For a Period of 142 Days to Expire on February 28, 1991;
Amended Eff. March 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1904 PROCEDURE FOR APPEAL

A hospital with nursing facility or adult care home beds may appeal any decision of the Department to deny, revoke or alter a license by making such an appeal in accordance with G.S. Chapter 150B.

History Note: *Authority G.S. 131E-79; 42 U.S.C. 1396 r (a);*
Eff. February 1, 1986;
Amended Eff. March 1, 1990;
Temporary Amendment Eff. October 1, 1990 For a Period of 142 Days to Expire on February 28, 1991;
Amended Eff. March 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1905 ADMISSIONS

(a) No patient shall be admitted except under the orders of a duly licensed physician.
(b) The facility shall acquire prior to or at the time of admission orders from the attending physician for the immediate care of the patient or resident.
(c) Within 48 hours of admission, the facility shall acquire medical information which shall include current medical findings, diagnosis, rehabilitation potential, a summary of the hospital stay if the patient is being transferred from a hospital, and orders for the ongoing care of the patient.
(d) If a patient is admitted from somewhere other than a hospital, a physical examination shall be performed either within 5 days prior to admission or within 48 hours following admission.
(e) Hospitals offering nursing facility or domiciliary home care as a new service must prepare a plan of admission which, at a minimum, assures availability of staff time and plans for individual patient assessments, initiation of health care or nursing care plans, and implementation of physician and nursing treatment plans. This plan must be available for inspection during the initial licensure survey prior to issuance of a license.
(f) Only persons who are 18 years of age or older shall be admitted to adult care home beds in a facility.

History Note: *Authority G.S. 131E-79; 42 U.S.C. 1396 r (a);*
Eff. February 1, 1986;
Amended Eff. March 1, 1990;
Temporary Amendment Eff. October 1, 1990 For a Period of 142 Days to Expire on February 28, 1991;
Amended Eff. March 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1906 POLICIES AND PROCEDURES

The governing board shall assure written policies and procedures which are available to and implemented by staff. These policies and procedures shall cover at least the following areas:

(1) admissions;
(2) dietary;
(3) discharges with physician orders and patients or residents leaving against physician advice;
(4) gratuities and solicitation which at a minimum shall provide that no owner, operator, agent or employee of a facility nor any member of his family shall accept a gratuity directly or indirectly from an patient or resident in the facility or solicit for any type of contribution;
(5) housekeeping;
(6) infection control which must include, but shall not be limited to, requirements for sterile, aseptic and isolation techniques; and communicable disease screening including, at a minimum, annual tuberculosis screening for all staff and inpatients of the facility;
(7) maintenance of patient medical or health care records including charging or record keeping;
(8) orientation of all facility personnel;
(9) patient or resident care plans, treatment and other health care or nursing care, including but not limited to all policies and procedures required by rules contained in this Subchapter;
(10) patients' or residents' rights;
(11) physical evaluation for residents and patients at least annually;
(12) physician services and utilization of the individual's private physician;
(13) procurement of supplies and equipment to meet individual patient care needs;
(14) protection of patients from abuse and neglect;
(15) range of services provided;
(16) recording and reporting to the department of accidents or incidents occurring to patients in any part of the facility and maintenance of such reports or records;
(17) rehabilitation services;
(18) release of medical record information;
(19) screening and reporting communicable disease to the local health department; and
(20) transfers.

History Note: *Authority G.S. 131E-79;*
Eff. February 1, 1986;

Amended Eff. March 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1907 GENERAL

The governing board shall assure that policies and procedures are available and implemented for assessing each patient's or resident's health care needs and planning for meeting identified health care needs. There shall be a system for evaluating the effectiveness of the assessment, planning and implementation (delivery of care processes) for each patient or resident.

History Note: Authority G.S. 131E-79;
Eff. February 1, 1986;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1908 FREQUENCY: METHOD AND CONTENT OF ASSESSMENT: PLANNING

Each patient's and resident's condition must be assessed on a regular, periodic basis, at least quarterly, with appropriate notation and updating of the health care plan. Health care planning for each patient and resident shall be an on-going process and must include, but shall not be limited to, the following:

(1) data which is systematically and continuously collected about his or her health status; the data shall be recorded so as to be accessible and communicated to all staff involved in the patient's or resident's care;

(2) current problems or needs identified and prioritized from a completed assessment relevant to the patient's or resident's response to aging, illness and general health status; and

(3) a current plan of care developed in conjunction with the patient or resident or legal guardian that includes measurable time related goals and approaches, or measures to be employed by various disciplines in order to achieve the identified goals.

History Note: Authority G.S. 131E-79;
Eff. February 1, 1986;
Amended Eff. March 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1909 IMPLEMENTATION OF HEALTH PLAN

All parts of the plan of care shall be assigned to specific disciplines or staff as indicated in the plan of care to assure that health care and rehabilitative services are performed daily and documented for those patients and residents who require such services.

History Note: Authority G.S. 131E-79;
Eff. February 1, 1986;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1910 NURSING/HEALTH CARE ADMINISTRATION AND SUPERVISION

(a) A licensed facility shall have a director of nursing service who shall be responsible for the overall organization and management of all nursing services and shall be currently licensed to practice as a registered nurse by the North Carolina Board of Nursing in accordance with G.S. 90, Article 9A.

(b) The Director of Nursing shall not serve as administrator or assistant administrator.

(c) A licensed facility with nursing facilities shall provide a full-time director of nursing on duty at least eight hours per day, five days a week. A registered nurse shall relieve the Director of Nursing (be in charge of nursing) during the Director's absence.

(d) A licensed facility shall employ and assign registered nurses, licensed practical nurses, nurse aides and nurse aide trainees for duties in accordance with G.S. 90, Article 9A.

(e) The Director of Nursing shall cause the following to be accomplished:

(1) establishment and implementation of nursing policies and procedures which shall include, but shall not be limited to the following:
   (A) assessment of and planning for patients' nursing care or health care needs, and implementation of nursing or health care plans;
   (B) daily charting of any unusual occurrences or acute episodes related to patient care, and progress notes written monthly reporting each patient's performance in accordance with identified goals and objectives and each patient's progress toward rehabilitative nursing goals;
   (C) assurance of the delivery of nursing services in accordance with physicians' orders, nursing care plans and the facility's policies and procedures;
   (D) notification of emergency physicians or on-call physicians;
   (E) infection control to prevent cross-infection among patients and staff;
   (F) reporting of deaths;
   (G) emergency reporting of fire, patient and staff accidents or incidents, or other emergency situations;
   (H) use of protective devices or restraints to assure that each patient or resident is restrained in accordance with physician orders and the facility's policies, and that the restrained patient or resident is appropriately evaluated and released at a minimum of every two hours;
   (I) special skin care and decubiti care;
   (J) bowel and bladder training;
   (K) maintenance of proper body alignment and restorative nursing care;
   (L) supervision of and assisting patients with feeding;
   (M) intake and output observation and reporting for those patients whose condition warrants monitoring of their fluid balance. This will include those patients on intravenous fluids or tube feedings, and patients with kidney failure and temperatures elevated to 102 degrees Fahrenheit or above;
   (N) catheter care; and
   (O) procedures used in caring for patients in the facility;
(2) development of written job descriptions for nursing personnel;
(3) periodic assessment of the nursing department with identification of personnel requirements as they relate to patient care needs and reporting same to the administrator;
(4) a planned orientation and continuing inservice education program for nursing employees and documentation of staff attendance and subject matter covered during inservice education programs;
(5) provision of appropriate reference materials for the nursing department, which includes a Physician's Desk Reference or comparable drug reference, policy and procedure manual, and medical dictionary for each nursing station; and
(6) establishment of operational procedures to assure that appropriate supplies and equipment are available to nursing staff as determined by individual patient care needs.

History Note: *Authority G.S. 131E-79; 42 U.S.C. 1396 r (a);*
Eff. February 1, 1986;
Amended Eff. March 1, 1990;
Temporary Amendment Eff. October 1, 1990 For a Period of 142 Days to Expire on February 28, 1991;
Amended Eff. March 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1911 VACANT DIRECTOR OF NURSING POSITION

(a) The administrator shall notify the Department within 72 hours when the director of nursing position becomes vacant and shall provide the name and license number of the individual who is acting director or the replacement for the director of nursing.
(b) A facility shall not operate without either a director of nursing or acting director or nursing.

(c) The administrator shall employ a director of nursing within 30 days after a position becomes vacant. A vacancy which exceeds 30 days shall be reviewed by the Department for action relative to licensure status of the facility.

History Note: Authority G.S. 131E-79;
Eff. February 1, 1986;
Amended Eff. March 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1912 NURSE STAFFING REQUIREMENTS

(a) A licensed facility shall provide licensed nursing personnel sufficient to accomplish the following:

(1) patient needs assessment,
(2) patient care planning, and
(3) supervisory functions in accordance with the level of patient or resident care advertised or offered by the facility.

The facility also shall provide other nursing personnel sufficient to assure that at least activities of daily living, personal grooming, restorative nursing actions and other health care needs as identified in each patient's or resident's plan of care are met.

(b) A licensed multi-storied facility (one having more than one story) shall provide at least one person on duty on each patient care floor at all times.

(c) Daily direct patient care nursing staff, licensed and unlicensed, shall equal or exceed 2.1 nursing hours per patient. (This is sometimes referred to as nursing hours per patient day or NHPPD or NH/PD.)

(1) Inclusive in these figures is the requirement that at least one licensed nurse is on duty for direct patient care at all time; and
(2) Nursing care shall include the services of a registered nurse for at least eight consecutive hours a day, seven days a week. This coverage can be spread over more than one shift if such a need exists. The Director of Nursing may be counted as meeting the requirements for both the Director of Nursing and patient and resident care staffing for facilities of a total census of 60 beds or less.

(d) Nursing support personnel including ward clerks, secretaries, nurse educators and persons in primarily administrative management positions and not actively involved in direct patient care shall not be counted toward compliance with minimum daily requirements for direct care staffing.

(e) All exceptions to meeting minimum staffing requirements shall be reported to the Department at the end of each month. Staffing waivers granted by the federal government for Medicare and Medicaid certified beds shall be accepted for licensure purposes.

(f) The ratio of male to female nurse aides will be determined by the needs of the patients, particularly the numbers of male patients requiring assistance with personal care.

History Note: Authority G.S. 131E-79; 42 U.S.C. 1396 r (b)(4)(C);
Eff. February 1, 1986;
Amended Eff. March 1, 1990;
Temporary Amendment Eff. October 1, 1990 For a Period of 142 Days to Expire on February 28, 1991;
Amended Eff. March 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1913 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .1914 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .1915 ADULT CARE HOME PERSONNEL REQUIREMENTS

(a) The administrator shall designate a person to be in charge of the adult care home residents at all times. The nurse in charge of nursing services may also serve as supervisor-in-charge of the adult care home beds.

(b) If adult care home beds are located in a separate building or a separate level of the same building, there shall be a person on duty in the adult care home areas at all times.

(c) A licensed facility shall provide staff to assure that activities of daily living, personal grooming, and assistance with eating are provided to each resident. Medication administration as indicated by each resident's condition or physician's orders shall be carried out as identified in each resident's plan of care.
(d) Adult care home facilities licensed as a part of a combination facility shall comply with the staffing requirements in 10A NCAC 13F .0605 herein incorporated by reference including subsequent amendments and editions.

History Note: *Authority G.S. 131E-79; 42 U.S.C. 1396 r (a);*
Eff. February 1, 1986;
Temporary Amendment Eff. October 1, 1990 For a Period of 142 Days to Expire on February 28, 1991;
Amended Eff. March 1, 1991;
Readopted Eff. April 1, 2020.

10A NCAC 13B .1916 REHABILITATIVE NURSING AND DECUBITUS CARE

Each patient or resident shall be given care to prevent contractures, deformities, and decubiti, including but not limited to:

(1) changing positions of bedfast and chairfast patients or residents every two hours and administering simple preventive care. Documentation of such care and outcome must be included in routine summaries or progress notes;
(2) maintaining proper alignment and joint movement to prevent contractures and deformities, which must be documented in routine summaries or progress notes;
(3) implementing an individualized bowel and bladder training program except for patients or residents whose records are documented that such training is not effective. A monthly summary for patients and quarterly summaries for domiciliary residents shall be written relative to each patient's or resident's performance in the bowel and bladder training program; and
(4) such other services as necessary to meet the needs of the patient.

History Note: *Authority G.S. 131E-79; 42 U.S.C. 1396 r (a);*
Eff. February 1, 1986;
Amended Eff. March 1, 1990;
Temporary Amendment Eff. October 1, 1990 For a Period of 142 Days to Expire on February 28, 1991;
Amended Eff. March 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1917 MEDICATION ADMINISTRATION

(a) A licensed facility shall have policies and procedures governing the administration of medications which shall be enforced and implemented by administration and staff. Policies and procedures shall include, but shall not be limited to:

(1) automatic stop orders for treatment and drugs;
(2) accountability of controlled substances as defined by the North Carolina Controlled Substances Act, G.S. 90, Article 5;
(3) dispensing and administering behavior modifying drugs, such as hypnotics, sedatives, tranquilizers, antidepressants and other psychotherapeutic agents; insulin; intravenous fluids and medications; cardiovascular regulating drugs; and antibiotics.

(b) All medications or drugs and treatments shall be administered and discontinued in accordance with signed physician's orders which are recorded in the patient's or resident's medical record.

(1) Only physicians, registered nurses, licensed practical nurses or physician assistants, if in accordance with the assistant's approved practice, shall administer medications.
(2) To ensure accountability, any medication shall be administered by the same licensed personnel who prepared the dose for administration. This Rule does not apply to the dispensing of medications from a pharmacy utilizing a unit of use drug delivery system.
(3) Medications shall be administered within a half hour prior to or half hour after the prescribed time for administration unless precluded by emergency situations.

(4) The person administering medications shall identify each patient or resident in accordance with the facility's policies and procedures prior to administering any medication.
(5) Medication administered to a patient or resident shall be recorded in the patient's or resident's medication administration record immediately after administration in accordance with the facility's policies and procedures.
(6) Omission of medication and the reason for the omission shall be indicated in the patient's or resident's medical record.
(7) The person administering medications which are ordered to be given as needed (PRN) shall justify the need for the same in the patient's or resident's medical record.
(8) Medication administration records shall provide identification of the drug and strength of drug, quantity of drug administered, name of administering employee, title of employee and time of administration.

(c) Self-administration of medications shall be permitted only if prescribed by a physician and directions are printed on the container.
(d) The administration of one patient's or resident's medications to another patient or resident is prohibited except in the case of an emergency. In the event of such an emergency, steps shall be taken to assure that the borrowed medications shall be replaced promptly and so documented.
(e) Verbal orders shall be countersigned by a physician within five days of issuance.

History Note: *Authority G.S. 131E-79;*
Eff. February 1, 1986;
Amended Eff. December 1, 1991; March 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1918 TRAINING

(a) A licensed facility shall provide patient or resident care employees a planned orientation and continuing education program emphasizing patient or resident assessment and planning, activities of daily living, personal grooming, rehabilitative nursing or restorative care, other patient or resident care policies and procedures, patients' rights, and staff performance expectations. Attendance and subject matter covered shall be documented for each session, retained in accordance with policy established by the facility, and available for licensure inspections.
(b) The administrator shall assure that employees are oriented within the first week of employment to the facility's philosophy and goals.
(c) Employees shall have specific on-the-job training as necessary to perform their individual job assignment.
(d) A nurse aide trainee may be employed to perform the duties of a nurse aide for a period of time not to exceed four months. During this period of time the nurse aide trainee shall be permitted to perform only those tasks that competence has been demonstrated and documented on the record. Nurse aide I shall meet the training and competency evaluation standards in 10A NCAC 13O .0301, incorporated herein by reference including subsequent amendments and editions. A record of nurse aide qualifications shall be maintained for each nurse aide used by a facility and shall be retained in the general personnel files of the facility in accordance with policy established by the facility.
(e) The initial orientation to the facility shall be exclusive of the Nurse Aide I training program. Competency evaluation shall be conducted in each of the following areas:

(1) Observation and documentation,
(2) Basic nursing skills,
(3) Personal care skills,
(4) Mental health and social service needs,
(5) Basic restorative services, and
(6) Residents' Rights.

History Note: *Authority G.S. 131E-79; 42 U.S.C. 1396 r (b)(5);*
Eff. February 1, 1986;
Temporary Rule Eff. October 1, 1990 For a Period of 142 Days to Expire on February 28, 1991;
Amended Eff. March 1, 1991; March 1, 1990;
Readopted Eff. April 1, 2020.

10A NCAC 13B .1919 DENTAL CARE

(a) A dental examination shall be performed at the time of admission with the following information being placed in the patient's or resident's medical or health care record:

(1) type of diet which the patient or resident can best manage (such as normal, soft or pureed);
(2) the presence of infection of gums, teeth, or jaws;
(3) brief descriptions of any removable dental appliances and a statement of their condition; and
(4) indications for dental treatment at the time of admission.

(b) Names of dentists who have agreed to render emergency dental care shall be maintained at each nursing station and at the supervisor's station in a adult care home.

(c) Staff of the facility shall ensure that:

(1) necessary daily dental care is provided;
(2) each patient or resident possesses appropriate toothbrushes and is encouraged and, when necessary, assisted in their use; and
(3) each patient or resident having a removable denture is furnished a receptacle in which to immerse the denture in water overnight.

History Note: Authority G.S. 131E-79;
Eff. February 1, 1986;
Amended Eff. March 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1920 AVAILABILITY OF PHARMACEUTICAL SERVICES

(a) A licensed facility shall provide pharmaceutical services under the supervision of a pharmacist currently licensed to practice pharmacy in North Carolina.

(b) A facility shall be responsible for obtaining drugs, therapeutic nutrients and related products prescribed or ordered by a physician for patients or residents in the facility.

(c) Services shall include documented on-site pharmaceutical reviews accomplished at least every 31 calendar days for all patients and residents.

History Note: Authority G.S. 131E-79;
Eff. February 1, 1986;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1921 DINING FACILITIES

Patients, including wheelchair patients, shall be encouraged to eat at the tables in the dining area and shall be assisted when necessary by non-dietary staff. An overbed table shall be provided for patients who eat in bed. A sturdy tray stand shall be provided for those patients who eat out of bed but are unable to go to the dining area. An overbed table which can be lowered to chair height may substitute for the tray stand.

History Note: Authority G.S. 131E-79;
Eff. February 1, 1986;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1922 ACTIVITIES AND RECREATION

(a) The administrator shall designate an activities and recreation director to be in charge of activities and recreation for all patients and residents. The activities and recreation director shall have training and experience in directing recreational and group activities. The designated activities and recreation director shall be under the supervision of the administrator and shall be qualified to meet the needs of the patients and residents. A qualified individual shall be anyone eligible for a N.C. license as an occupational therapist or assistant therapist under G.S. 90-270; anyone eligible for N.C. certification as a recreation therapist or assistant therapist under G.S. 90C-9; anyone with a baccalaureate degree and one year experience; anyone who has completed an approved 36-hour or longer course in activities program management; or anyone not otherwise qualified but receiving at least four hours consultation per month from one who is qualified.

(b) The facility shall maintain and make available a listing of local resources for activities and recreation to be utilized in meeting the needs and interests of all patients and residents.
(c) Restoration to self care and resumption of normal activity shall be one of the main goals of the recreation or activity program. The scope of the activity program shall include:

(1) social activities involving individual and group participation which are designed to promote group relationships;
(2) recreational activities, both indoor and outdoor;
(3) opportunity to participate in activities outside the facility;
(4) religious programs, including the right of each patient and resident to attend the church or religious program of his choice;
(5) creative and expressive activities;
(6) educational activities; and
(7) exercise.

(d) The facility shall have written policies and procedures which are available and implemented by staff that:

(1) attempt to prevent the further mental or physical deterioration for those patients or residents who cannot realistically resume normal activities;
(2) assure opportunities for patient involvement, both individual and group, in both planning and implementing the activity program;
(3) provide patients or residents the opportunity for choice among a variety of activities; and
(4) encourage participation by each patient or resident in social and recreational activities according to individual need and abilities and desires unless the patient's or resident's record contains documentation that he is unable to participate.

(e) Each patient's or resident's activity plan shall be a part of his overall plan of care and shall contain documentation of periodic assessments of the individual's activity needs and interests. A record of activities and individuals participating shall be maintained in the facility.
(f) A licensed facility shall display a monthly activities calendar which includes variety to appeal to different interest groups in the nursing care and adult care home services.
(g) A licensed facility shall provide:

(1) Space for recreational and diversional activities. In hospitals offering new nursing home services, space shall be provided separately from the main living and dining areas; however, these areas may also be used for social activities.
(2) Designated indoor and outdoor activity areas for independent and group needs of patients and residents, and which are:
    (A) accessible to wheelchair and ambulatory patients; and
    (B) of sufficient size to accommodate necessary equipment and permit unobstructed movement of wheelchair and ambulatory patients or personnel responsible for instruction and supervision.
(3) Adequate space to store equipment and supplies without blocking exists or otherwise threatening the health and safety of patients and residents.

(h) There shall be equipment and supplies sufficient to carry out planned programs for both individual and group activities.

History Note: Authority G.S. 131E-79; 42 U.S.C. 1396 r (a);
Eff. February 1, 1986;
Amended Eff. March 1, 1990;
Temporary Amendment Eff. October 1, 1990 For a Period of 142 Days to Expire on February 1, 1991;
Amended Eff. March 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1923 SOCIAL SERVICES

(a) The administrator shall designate an employee to be responsible for the provision of social services. This person shall be known as the social services director. Subsequent to the effective date of the rules contained in this Subchapter any newly designated person must be a graduate of a four year college or university with one year's experience in the health care or long-term care field or have an equivalent combination of education and experience.

An equivalent combination of education and experience means the number of years of education leading to a baccalaureate or associate degree plus the number of years of long-term nursing facility experience equal to five years; or eligible for certification as a social worker pursuant to G.S. 90B-7. The social services director shall have authority to carry out provisions contained in Rule .1923(b) of this Section.

(b) Each patient's or resident's plan of care shall contain a written plan for meeting his individual social needs and involving his active participation, the plan shall provide for:

(1) needed assistance in meeting the patient's or resident's physical, social and emotional needs through consultation with the patient or resident or his legal guardian, and relative, physician or others;

(2) assisting the patient or resident in adjusting to his environment, for referral to other supporting resources, for protective services, for financial services and for assistance at the time of discharge or transfer into a new environment;

(3) the utilization of caseworkers employed by the county department of social services in the case of recipients of public assistance and for the utilization of appropriate persons with experience and training in the general area of social work in the case of those not on public assistance.

(c) Discharge planning shall be in keeping with each patient's and resident's discharge needs. These are as follows:

(1) The administrator shall assure that a medical order for discharge including any special instructions for meeting rehabilitation potential is obtained from all patients or residents except when a patient or resident leaves against a physician's order or advice; and

(2) The social services director shall coordinate discharge instructions and assure that patients and residents and their families are instructed in accordance with discharge orders.

History Note: *Authority G.S. 131E-79;*
Eff. February 1, 1986;
Amended Eff. March 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1924 RESTRAINTS

(a) Patients and residents shall be restrained only by physician orders.

(b) The nurse in charge shall be responsible for making the decision relative to necessity for, type and duration of restraint in emergency situations requiring restraints while contacting the physician. The nurse also shall be responsible for documenting same in the patient's or resident's record.

(c) The type of restraint used and the time of application and removal shall be recorded by a licensed nurse in the patient's or resident's record.

History Note: *Authority G.S. 131E-79;*
Eff. February 1, 1986;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1925 REQUIRED SPACES

(a) A combination or nursing facility shall meet the following requirements for bedrooms, dining, recreation, and common use areas:

(1) single bedrooms shall be provided with not less than 100 square feet of floor area;

(2) bedrooms with more than one bed shall be provided with not less than 80 square feet of floor area per bed;

(3) dining, recreation, and common use areas shall:

(A) total not less than 25 square feet of floor area per bed for skilled nursing and intermediate care beds;

(B) total not less than 30 square feet of floor area per bed for adult care home beds; and

(C) be contiguous to patient and resident bedrooms.

(b) Floor space for the following rooms, areas, and furniture shall not be included in the floor areas required by Paragraph (a) of this Rule:

(1) toilet rooms;

(2) vestibules;

(3) bath areas;
(4) closets;
(5) lockers;
(6) built-in furniture;
(7) movable wardrobes;
(6) corridors; and
(7) areas for physical and occupational therapy.

History Note: *Authority G.S. 131E-79;*
Eff. February 1, 1986;
Readopted Eff. April 1, 2020.

10A NCAC 13B .1926 NURSING HOME PATIENT OR RESIDENT RIGHTS

(a) Written policies and procedures shall be developed and enforced to implement requirements in G.S. 131E-115 et seq. (Nursing Home Patients' Bill of Rights) concerning the rights of patients and residents. The administrator shall make these policies and procedures known to the staff, patients and residents, and families of patients and residents and shall ensure their availability to the public by placing them in a conspicuous place.
(b) Any violation of patient rights contained in G.S. 131E-117 shall be determined by representatives of the Department by investigation or survey.
(c) If a licensed facility is found to be in violation of any of the rights contained in G.S. 131E-117, the Department shall impose penalties for each violation as provided by G.S. 131E-129.
(d) When the Department has been notified that corrective action has been taken for each violation, verification of same shall be made by a representative of the Department.
(e) The Department shall calculate a total of all fines levied against a facility based on the number of violations and the number of days and patients or residents involved in each violation.
(f) The Department shall mail a statement to the facility showing a total fine for each violation and a total of fines due to be paid for all violations. The facility shall pay the penalty within 60 days unless a hearing is requested under G.S. Chapter 150B.
(g) When it is found that a violation of G.S. 131E-117 has occurred but corrective action was taken prior to the date of discovery, fines shall be calculated and assessed in accordance with (e) and (f) of this Rule.
(h) In matters of patient abuse, neglect or misappropriation the definitions shall have the meanings defined for abuse, neglect and exploitation respectively as contained in the North Carolina PROTECTION OF THE ABUSED, NEGLECTED OR EXPLOITED DISABLED ADULT ACT, G.S. 108A-99 et seq.

History Note: *Authority G.S. 131E-79; 42 U.S.C. 1396 r (e)(2)(B);*
Eff. February 1, 1986;
Amended Eff. March 1, 1990;
Temporary Amendment Eff. October 1, 1990 For a Period of 142 Days to Expire on February 28, 1991;
Amended Eff. March 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1927 BRAIN INJURY LONG-TERM CARE PHYSICIAN SERVICES

(a) For nursing facility patients located in designated brain injury long-term care units, there shall be an attending physician who is responsible for the patient's specialized care program. The intensity of the program requires that there shall be direct patient contact by a physician at least once per week and more often as the patient's condition warrants. Each patient's interdisciplinary, long-term care program shall be developed and implemented under the supervision of a physiatrist (a physician trained in Physical Medicine and Rehabilitation) or a physician of equivalent training and experience.
(b) If a physiatrist or physician of equivalent training or experience, is not available on a weekly basis to the facility, the facility shall provide for weekly medical management of the patient, by another physician. In addition, oversight for the patient's interdisciplinary, long-term care program shall be provided by a qualified consultant physician who visits patients monthly, makes recommendations for and approves the interdisciplinary care plan, and provides consultation as requested to the physician who is managing the patient on a weekly basis.

(c) The attending physician shall actively participate in individual case conferences or care planning sessions and shall review and sign discharge summaries and records within 15 days of patient discharge. When patients are to be discharged to either another health care facility or a residential setting the attending physician shall assure that the patient has been provided with a discharge plan which incorporates optimum utilization of community resources and post discharge continuity of care and services.

History Note: *Authority G.S. 131E-79;*
Eff. December 1, 1991;
Amended Eff. February 1, 1993;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1928 BRAIN INJURY LONG-TERM CARE PROGRAM REQUIREMENTS

History Note: *Authority G.S. 131E-79;*
Eff. December 1, 1991;
Amended Eff. February 1, 1993;
Expired Eff. August 1, 2017 pursuant to G.S. 150B-21.3A.

10A NCAC 13B .1929 SPECIAL NURSING REQUIREMENTS FOR BRAIN INJURY LONG-TERM CARE

Direct care nursing personnel staffing ratio (NH/PD) established in Rule .1912 of this Section shall not be applied to nursing services for patients who require brain injury long-term care, due to their more intensive maintenance and nursing needs. The minimum direct care nursing staff shall be 5.5 hrs. per patient day allocated on a per shift basis as the facility chooses to appropriately meet the patient's needs. It is also required that regardless of how low the patient census the direct care nursing staff shall not fall below a registered nurse and a nurse aide I at any time during a 24-hour period.

History Note: *Authority G.S. 131E-79;*
Eff. December 1, 1991;
Amended Eff. February 1, 1993;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1930 VENTILATOR DEPENDENCE

The general requirements in this Subchapter shall apply when applicable. In addition, facilities having patients requiring the use of ventilators for more than eight hours a day must meet the following requirements:

(1) Respiratory therapy shall be provided and supervised by a respiratory therapist currently registered by the National Board for Respiratory Care. The respiratory therapist shall:
   (a) make, as a minimum, weekly on-site assessments of each patient receiving ventilator support with corresponding progress notes;
   (b) be on-call 24 hours daily; and
   (c) assist the pulmonologist and nursing staff in establishing ventilator policies and procedures, including emergency policies and procedures.

(2) Direct nursing care staffing shall be in accordance with Rule .1912 of this Section.

History Note: *Authority G.S. 131E-79;*
Eff. December 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1931 PHYSICIAN SERVICES FOR VENTILATOR DEPENDENT PATIENTS

Hospitals with nursing facility beds with ventilator dependent care patients shall contract with a physician who is licensed to practice in North Carolina with Board Certification and who has specialized training in pulmonary medicine. This physician shall be responsible for respiratory services and shall:

(1) establish, with the respiratory therapist and nursing staff, appropriate ventilator policies and procedures, including emergency procedures;
(2) assess each ventilator patient's status at least monthly with corresponding progress notes;
(3) be available on an emergency basis; and
(4) participate in individual patient case planning.

History Note: Authority G.S. 131E-79;
Eff. December 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .1932 EMERGENCY ELECTRICAL SERVICE

(a) A minimum of one dedicated emergency branch circuit per bed is required for ventilator dependent patients in addition to the normal system receptacle at each bed location required by the National Electrical Code. This emergency circuit shall be provided with a minimum of two duplex receptacles identified for emergency use. Additional emergency branch circuits/receptacles shall be provided where the electrical life support needs of the patient exceed the minimum requirements stated in this Paragraph. Each emergency circuit serving ventilator dependent patients shall be fed from the automatically transferred critical branch of the essential electrical system. This Paragraph shall apply to both new and existing facilities.
(b) Heating equipment provided for ventilator dependent patient bedrooms shall be connected to the critical branch of the essential electrical system and arranged for delayed automatic or manual connection to the emergency power source if the heating equipment depends upon electricity for proper operation. This Paragraph shall apply to both new and existing facilities.
(c) Task lighting connected to the automatically transferred critical branch of the essential electrical system shall be provided for each ventilator dependent patient bedroom. This Paragraph shall apply to both new and existing facilities.

History Note: Authority G.S. 131E-79;
Eff. December 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

SECTION .2000 – SPECIALIZED REHABILITATIVE AND HABILITATIVE SERVICES

10A NCAC 13B .2001 ADMISSIONS TO THE HIV DESIGNATED UNIT
10A NCAC 13B .2002 DISCHARGE OF PATIENTS FROM THE HIV DESIGNATED UNIT
10A NCAC 13B .2003 HIV DESIGNATED UNIT POLICIES AND PROCEDURES
10A NCAC 13B .2004 PHYSICIAN SERVICES IN A HIV DESIGNATED UNIT
10A NCAC 13B .2005 SPECIAL NURSING REQUIREMENTS FOR A HIV DESIGNATED UNIT
10A NCAC 13B .2006 SPECIALIZED STAFF EDUCATION FOR THE HIV DESIGNATED UNIT
10A NCAC 13B .2007 USE OF INVESTIGATIONAL DRUGS ON THE HIV DESIGNATED UNIT
10A NCAC 13B .2008 SOCIAL WORK SERVICES IN A HIV DESIGNATED UNIT

History Note: Authority G.S. 131E-79;
Eff. February 1, 1993;
Expired Eff. August 1, 2017 pursuant to G.S. 150B-21.3A.

10A NCAC 13B .2009 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .2010 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .2011 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .2012 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .2013 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .2014 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .2015 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .2016 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .2017 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .2018 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .2019 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .2020 DEFINITIONS

The following definitions shall apply to inpatient rehabilitation facilities or units only:

(1) "Case management" means the coordination of services, for a given patient, between disciplines so that the patient may reach optimal rehabilitation through the judicious use of resources.

(2) "Comprehensive, inpatient rehabilitation program" means a program for the treatment of persons with functional limitations or chronic disabling conditions who have the potential to achieve a significant improvement in activities of daily living. A comprehensive, rehabilitation program utilizes a coordinated and integrated, interdisciplinary approach, directed by a physician, to assess patient needs and to provide treatment and evaluation of physical, psycho-social and cognitive deficits.

(3) "Inpatient rehabilitation facility or unit" means a free-standing facility or a unit (unit pertains to contiguous dedicated beds and spaces) within an existing licensed health service facility approved in accordance with G.S. 131E, Article 9 to establish inpatient, rehabilitation beds and to provide a comprehensive, inpatient rehabilitation program.

(4) "Medical consultations" means consultations which the rehabilitation physician or the attending physician determine are necessary to meet the acute medical needs of the patient and do not include routine medical needs.

(5) "Occupational therapist" means any individual licensed in the State of North Carolina as an occupational therapist in accordance with the provisions of G.S. 90, Article 18D.

(6) "Occupational therapist assistant" means any individual licensed in the State of North Carolina as an occupational therapist assistant in accordance with the provisions of G.S. 90, Article 18D.

(7) "Psychologist" means a person licensed as a practicing psychologist in accordance with G.S. 90, Article 18A.

(8) "Physiatrist" means a licensed physician who has completed a physical medicine and rehabilitation residency training program approved by the Accreditation Council of Graduate Medical Education or the American Osteopathic Association.

(9) "Physical therapist" means any person licensed in the State of North Carolina as a physical therapist in accordance with the provisions of G.S. 90, Article 18B.

(10) "Physical therapist assistant" means any person duly licensed in the State of North Carolina as a physical therapist assistant in accordance with the provisions of G.S. 90-270.24, Article 18B.

(11) "Recreational therapist" means a person certified by the State of North Carolina Therapeutic Recreational Certification Board.

(12) "Rehabilitation nurse" means a registered nurse licensed in North Carolina, with training, either academic or on-the-job, in physical rehabilitation nursing and at least one year experience in physical rehabilitation nursing.

(13) "Rehabilitation aide" means an unlicensed assistant who works under the supervision of a registered nurse, licensed physical therapist or occupational therapist in accordance with the appropriate occupational licensure laws governing his or her supervisor and consistent with staffing requirements as set forth in Rule .2027 of this Section. The rehabilitation aide shall be listed on the North Carolina Nurse Aide Registry and have received additional staff training as listed in Rule .2028 of this Section.

(14) "Rehabilitation physician" means a physiatrist or a physician who is qualified, based on education, training and experience regardless of specialty, of providing medical care to rehabilitation patients.

(15) "Social worker" means a person certified by the North Carolina Social Work Certification and Licensure Board in accordance with G.S. 90B-3.

(16) "Speech and language pathologist" means any person licensed in the State of North Carolina as a speech and language pathologist in accordance with the provisions of G.S. 90, Article 22.

History Note: Authority G.S. 131E-79; 143B-165;
Eff. May 1, 1993;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .2021 PHYSICIAN REQS FOR INPATIENT REHABILITATION FACILITIES OR UNITS
10A NCAC 13B .2022 ADMISSION CRITERIA FOR INPATIENT REHABILITATION FACILITIES OR UNITS
10A NCAC 13B .2023 COMPREHENSIVE INPATIENT REHABILITATION EVALUATION
10A NCAC 13B .2024 COMPREHENSIVE INPATIENT REHABILITATION INTERDISCIPLINARY TREAT/PLAN
10A NCAC 13B .2025 DISCHARGE CRITERIA FOR INPATIENT REHABILITATION FACILITIES OR UNITS
10A NCAC 13B .2026 COMPREHENSIVE REHABILITATION PERSONNEL ADMINISTRATION
10A NCAC 13B .2027 COMPREHENSIVE INPATIENT REHABILITATION PROGRAM STAFFING REQS
10A NCAC 13B .2028 STAFF TRAINING FOR INPATIENT REHABILITATION FACILITIES OR UNIT
10A NCAC 13B .2029 EQUIPMENT REQS/COMPREHENSIVE INPATIENT REHABILITATION PROGRAMS
10A NCAC 13B .2030 PHYSICAL FACILITY REQS/INPATIENT REHABILITATION FACILITIES OR UNITS
10A NCAC 13B .2031 ADDITIONAL REQUIREMENTS FOR TRAUMATIC BRAIN INJURY PATIENTS
10A NCAC 13B .2032 ADDITIONAL REQUIREMENTS FOR SPINAL CORD INJURY PATIENTS

History Note: Authority G.S. 131E-79; 143B-165;
Eff. May 1, 1993;
Amended Eff. December 1, 1993;
Expired Eff. August 1, 2017 pursuant to G.S. 150B-21.3A.

10A NCAC 13B .2033 DEEMED STATUS FOR INPATIENT REHABILITATION FACILITIES OR UNITS

(a) If an inpatient rehabilitation facility or unit with a comprehensive inpatient rehabilitation program is surveyed and accredited by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF) and has been approved by the Department in accordance with Article 9 Chapter 131E of the North Carolina General Statutes, the Department deems the facility to be in compliance with Rules .2020 through .2030 and .2033 of this Section.

(b) Deemed status shall be provided only if the inpatient rehabilitation facility or unit provides copies of survey reports to the Division. The JCAHO report shall show that the facility or unit was surveyed for rehabilitation services. The CARF report shall show that the facility or unit was surveyed for comprehensive rehabilitation services. The facility or unit shall sign an agreement (Memorandum of Understanding) specifying these terms.

(c) The inpatient rehabilitation facility or unit shall be subject to inspections or complaint investigations by representatives of the Department at any time. If the facility or unit is found not to be in compliance with the rules listed in Paragraph (a) of this Rule, the facility shall submit a plan of correction and be subject to a follow-up visit to assure compliance.

(d) If the inpatient rehabilitation facility or unit loses or does not renew its accreditation, the facility or unit shall notify the Division in writing within 30 days.

History Note: Authority G.S. 131E-79;

Eff. May 1, 1993;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

SECTION .2100 – TRANSPARENCY IN HEALTH CARE COSTS

10A NCAC 13B .2101 DEFINITIONS

In addition to the terms defined in G.S. 131E-214.13, the following terms shall apply throughout this Section, unless text indicates to the contrary:

(1) "Current Procedural Terminology (CPT)" means a medical code set developed by the American Medical Association.
(2) "Diagnostic related group (DRG)" means a system to classify hospital cases assigned by a grouper program based on ICD (International Classification of Diseases) diagnoses, procedures, patient's age, sex, discharge status, and the presence of complications or co-morbidities.
(3) "Department" means the North Carolina Department of Health and Human Services.
(4) "Financial assistance" means a policy, including charity care, describing how the organization will provide assistance at its hospital(s) and any other facilities. Financial assistance includes free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are unable to pay for all or a portion of the services. Financial assistance does not include:
 (a) bad debt;
 (b) uncollectable charges that the organization recorded as revenue but wrote off due to a patient's failure to pay;
 (c) the cost of providing such care to the patients in Sub-Item (4)(b) of this Rule; or
 (d) the difference between the cost of care provided under Medicare or other government programs, and the revenue derived therefrom.
(5) "Healthcare Common Procedure Coding System (HCPCS)" means a three-tiered medical code set consisting of Level I, II and III services and contains the CPT code set in Level I.

History Note: Authority G.S. 131E-214.13;
Temporary Adoption Eff. December 31, 2014;
Eff. September 30, 2015.

10A NCAC 13B .2102 REPORTING REQUIREMENTS

(a) The Department shall establish the lists of the statewide 100 most frequently reported DRGs, 20 most common outpatient imaging procedures, and 20 most common outpatient surgical procedures performed in the hospital setting to be used for reporting the data required in Paragraphs (c) through (e) of this Rule. The lists shall be determined annually based upon data provided by the certified statewide data processor. The Department shall make the lists available on its website. The methodology to be used by the certified statewide data processor for determining the lists shall be based on the data collected from all licensed facilities in the State in accordance with G.S. 131E-214.2 as follows:

(1) the 100 most frequently reported DRGs shall be based upon all hospital's discharge data that has been assigned a DRG based on the Centers for Medicare & Medicaid Services grouper for each patient record, then selecting the top 100 to be provided to the Department;
(2) the 20 most common imaging procedures shall be based upon all outpatient data for both hospitals and ambulatory surgical facilities and represent all occurrences of the diagnostic radiology imaging codes section of the CPT codes, then selecting the top 20 to be provided to the Department; and
(3) the 20 most common outpatient surgical procedures shall be based upon the primary procedure code from the ambulatory surgical facilities and represent all occurrences of the surgical codes section of the CPT codes, then selecting the top 20 to be provided to the Department.

(b) Information required or reported in Paragraphs (a), (c), (d), and (i) of this Rule shall be posted on the Department's website at: http://www.ncdhhs.gov/dhsr/ahc and may be accessed at no cost.

(c) In accordance with G.S. 131E-214.13, all licensed hospitals shall report the data required in Paragraph (e) of this Rule related to the statewide 100 most frequently reported DRGs to the certified statewide data processor in a format provided by the certified statewide processor. Commencing with the reporting period ending September 30, 2015,

an annual data report shall be submitted that includes all sites operated by the licensed hospital. Each annual report shall be submitted by the due date of January 1.

(d) In accordance with G.S. 131E-214.13, all licensed hospitals shall report the data required in Paragraph (e) of this Rule related to the statewide 20 most common outpatient imaging procedures and the statewide 20 most common outpatient surgical procedures to the certified statewide data processor in a format provided by the certified statewide processor. This report shall include the related primary CPT and HCPCS codes. Commencing with the reporting period ending September 30, 2015, an annual data report shall be submitted that includes all sites operated by the licensed hospital. Each annual report shall be submitted by January 1.

(e) The reports as described in Paragraphs (c) and (d) of this Rule shall be specific to each reporting hospital and shall include:

(1) the average gross charge for each DRG, CPT code, or procedure without a public or private third party payer source;

(2) the average negotiated settlement on the amount that will be charged for each DRG, CPT code, or procedure as required for patients defined in Subparagraph (e)(1) of this Rule. The average negotiated settlement shall be calculated using the average amount charged all patients eligible for the hospital's financial assistance policy, including self-pay patients;

(3) the amount of Medicaid reimbursement for each DRG, CPT code, or procedure, including all supplemental payments to and from the hospital;

(4) the amount of Medicare reimbursement for each DRG, CPT code, or procedure; and

(5) on behalf of patients who are covered by a Department of Insurance licensed third-party and teachers and State employees, the lowest, average, and highest amount of payments made for each DRG, CPT code, or procedure by each of the hospital's top five largest health insurers.

  (A) each hospital shall determine its five largest health insurers based on the dollar volume of payments received from those insurers;

  (B) the lowest amount of payment shall be reported as the lowest payment from each of the five insurers on the DRG, CPT code, or procedure;

  (C) the average amount of payment shall be reported as the arithmetic average of each of the five health insurers payment amounts;

  (D) the highest amount of payment shall be reported as the highest payment from each of the five insurers on the DRG, CPT code, or procedure; and

  (E) the identity of the top five largest health insurers shall be redacted prior to submission.

(f) The data reported, as defined in Paragraphs (c) through (e) of this Rule, shall reflect the payments received from patients and health insurers for all closed accounts. For the purpose of this Rule, "closed accounts" are patient accounts with a zero balance at the end of the data reporting period.

(g) A minimum of three data elements shall be required for reporting under Paragraphs (c) and (d) of this Rule.

(h) The information submitted in the report shall be in compliance with the federal Health Insurance Portability and Accountability Act of 1996, 45 CFR Part 164.

(i) The Department shall provide the location of each licensed hospital and all specific hospital data reported pursuant to this Rule on its website. Hospitals shall be grouped by category on the website. On each quarterly report, hospitals shall determine one category that most accurately describes the type of facility. The categories are:

(1) "Academic Medical Center Teaching Hospital," means a hospital as defined in Policy AC-3 of the N.C. State Medical Facilities Plan. The N.C. State Medical Facilities Plan may be accessed at: http://www.ncdhhs.gov/dhsr/ncsmfp at no cost.

(2) "Teaching Hospital," means a hospital that provides medical training to individuals, provided that such educational programs are accredited by the Accreditation Council for Graduated Medical Education to receive graduate medical education funds from the Centers for Medicare & Medicaid Services.

(3) "Community Hospital," means a general acute hospital that provides diagnostic and medical treatment, either surgical or nonsurgical, to inpatients with a variety of medical conditions, and that may provide outpatient services, anatomical pathology services, diagnostic imaging services, clinical laboratory services, operating room services, and pharmacy services, that is not defined by the categories listed in this Subparagraph and Subparagraphs (i)(1), (2), or (5) of this Rule.

(4) "Critical Access Hospital," means a hospital defined in the Centers for Medicare & Medicaid Services' State Operations Manual, Chapter 2 – The Certification Process, 2254D – Requirements for Critical Access Hospitals (Rev. 1, 05-21-04), including all subsequent updates and revisions.

The manual may be accessed at the website: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf at no cost.

(5) "Mental Health Hospital," means a hospital providing psychiatric services pursuant to G.S. 131E-176(21).

History Note: Authority G.S. 131E-214.4; 131E-214.13;
Temporary Adoption Eff. December 31, 2014;
Eff. September 30, 2015;
Temporary Amendment Eff. March 31, 2016;
Amended Eff. January 31, 2017.

SECTION .2200 - RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .2200 RESERVED FOR FUTURE CODIFICATION

SECTION .2300 - RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .2300 RESERVED FOR FUTURE CODIFICATION

SECTION .2400 - RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .2400 RESERVED FOR FUTURE CODIFICATION

SECTION .2500 - RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .2500 RESERVED FOR FUTURE CODIFICATION

SECTION .2600 - RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .2600 RESERVED FOR FUTURE CODIFICATION

SECTION .2700 - RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .2700 RESERVED FOR FUTURE CODIFICATION

SECTION .2800 - RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .2800 RESERVED FOR FUTURE CODIFICATION

SECTION .2900 - RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .2900 RESERVED FOR FUTURE CODIFICATION

SECTION .3000 - GENERAL INFORMATION

10A NCAC 13B .3001 DEFINITIONS

Notwithstanding Section .1900 of this Subchapter, the following definitions shall apply throughout this Subchapter unless the context indicates to the contrary:

(1) "Appropriate" means suitable or fitting, or conforming to standards of care as established by professional organizations, including Association of Professionals in Infection Control and Epidemiology (APIC), American Medical Association (AMA) and American Nurses Association (ANA).

(2) "Authority having jurisdiction" means the Division of Health Service Regulation.

(3) "Certified Dietary Manager" or "CDM" means an individual who is certified by the Certifying Board of the Dietary Managers and meets the standards and qualification as referenced in the "Dietary Manager Training Program Requirements." These standards include any subsequent

amendments and editions of the referenced manual. Copies of the "Dietary Manager Training Program Requirements" may be obtained free of charge at https://www.cbdmonline.org/.

(4) "Competence" means the state or quality of being able to perform specific functions well; skill; and ability.

(5) "Construction documents" means final building plans and specifications for the construction of a facility that a governing body submits to the Construction Section for approval as specified in Rule .3102 of this Subchapter.

(6) "Construction Section" means the Construction Section of the Division of Health Service Regulation.

(7) "Continuous" means ongoing or uninterrupted, 24 hours per day.

(8) "CRNA" means a Certified Registered Nurse Anesthetist who meets the criteria set forth in G.S. 90-171.21(d)(4).

(9) "Credentialed" means that the individual having a given title or position has been credited with the right to exercise official responsibilities to provide specific patient care and treatment services, within defined limits, based upon the individual's license, education, training, experience, competence, and judgment.

(10) "Department" means the Department of Health and Human Services.

(11) "Dietetics" means as defined in G.S. 90-352.

(12) "Dietitian" means a person who meets the criteria set forth in G.S. 90, Article 25.

(13) "Direct Supervision" means the state of being under the control of a supervisor, manager, or other person of authority.

(14) "Division" means the Division of Health Service Regulation.

(15) "Facility" means a hospital as defined in G.S. 131E-76.

(16) "Full-time equivalent" means a unit of measure of employee work time that is equal to the number of hours that one full-time employee would work during one calendar year if the employee worked eight hours a day, five days a week, and 52 weeks a year; i.e. 2,080 hours per year.

(17) "Governing body" means the authority as defined in G.S. 131E-76.

(18) "Imaging" means a reproduction or representation of a body or body part for diagnostic purposes by radiologic intervention that may include conventional fluoroscopic exam, magnetic resonance, nuclear or radio-isotope scan.

(19) "Invasive procedure" means a procedure involving puncture or incision of the skin, insertion of an instrument or foreign material into the body (excluding venipuncture and intravenous therapy).

(20) "License" means formal permission to provide services as granted by the State.

(21) "Medical staff" means the formal organization that is comprised of individuals who have sought and obtained clinical privileges in a facility. As defined by the facility's medical staff bylaws, rules and regulations, those members of the medical staff who regularly and routinely admit patients to a facility constitute the active medical staff.

(22) "Mission statement" means a written statement of the philosophy and beliefs of the organization or hospital as approved by the governing body.

(23) "Neonate" means the newborn from birth to one month.

(24) "Nurse executive" means a registered nurse who is the director of nursing services or a representative of decentralized nursing management staff.

(25) "Nurse midwife" means a person who meets the criteria as set forth in G.S. 90-171.21(d)(4).

(26) "Nursing facility" means as defined in G.S. 131E-116(2).

(27) "Nursing staff" means the registered nurses, licensed practical nurses, nurse aides, and others under nurse supervision, who provide patient care. The term also includes clerical personnel who work in clinical areas under nurse supervision.

(28) "Nutrition and Dietetic Technician Registered" means as defined by the Academy of Nutrition and Dietetics. A copy of the requirements can be obtained at https://www.eatrightpro.org/about-us/what-is-an-rdn-and-dtr/what-is-a-nutrition-and-dietetics-technician-registered at no cost.

(29) "Nutrition therapy" ranges from intervention and counseling on diet modification to administration of specialized nutrition therapies as determined necessary to manage a condition or treat illness or injury. Specialized nutrition therapies include supplementation with medical foods, enteral and parenteral nutrition. Nutrition therapy integrates information from the nutrition assessment with information on food and other sources of nutrients and meal preparation consistent with cultural background and socioeconomic status.

(30) "Observation bed" means a bed used for no more than 24-hours, to evaluate and determine the condition and disposition of a patient and is not considered a part of the hospital's licensed bed capacity.
(31) "Patient" means any person receiving diagnostic or medical services at a hospital.
(32) "Pharmacist" means as defined in G.S. 90-85.3.
(33) "Physical Rehabilitation Services" means any combination of physical therapy, occupational therapy, speech therapy, or vocational rehabilitation.
(34) "Physician" means a person who meets the criteria set forth in G.S.90-9.1 or G.S. 90-9.2.
(35) "Provisional license" means a hospital license recognizing less than full compliance with the licensure rules.
(36) "Qualified" means having complied with the specific conditions for employment or the performance of a function.
(37) "Reference" means to use in consultation to obtain information.
(38) "Special Care Unit" means a unit or area of a hospital that includes a critical care unit, an intermediate care unit, or a pediatric care unit.
(39) "Unit" means a designated area of the hospital for the delivery of patient care services.

History Note: *Authority G.S. 131E-79;*
RRC Objection due to lack of Statutory Authority Eff. July 13, 1995;
Eff. January 1, 1996;
Readopted Eff. April 1, 2020.

SECTION .3100 - PROCEDURE

10A NCAC 13B .3101 GENERAL REQUIREMENTS

(a) An application for licensure shall be submitted to the Division prior to a license being issued or patients admitted.
(b) An existing facility shall not sell, lease, or subdivide a portion of its bed capacity without the approval of the Division.
(c) Application forms may be obtained by contacting the Division.
(d) The Division shall be notified in writing 30 days prior to the occurrence of any of the following:
(1) addition or deletion of a licensable service;
(2) increase or decrease in bed capacity;
(3) change of chief executive officer;
(4) change of mailing address;
(5) ownership change; or
(6) name change.
(e) Each application shall contain the following information:
(1) legal identity of applicant;
(2) name or names used to present the hospital or services to the public;
(3) name of the chief executive officer;
(4) ownership disclosure;
(5) bed complement;
(6) bed utilization data;
(7) accreditation data;
(8) physical plant inspection data; and
(9) service data.
(f) A license shall include only facilities or premises within a single county.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Amended Eff. April 1, 2003;
Readopted Eff. April 1, 2020.

10A NCAC 13B .3102 PLAN APPROVAL

(a) For the purposes of this Rule, the Guidelines for the Design and Construction of Hospitals and Outpatient Facilities that is incorporated by reference in Rule .6105 of this Subchapter shall be referred to as the "FGI Guidelines."
(b) The definitions as set forth in Rule .6003 of this Subchapter shall apply to this Rule.
(c) The facility design and construction shall be in accordance with this Rule and the standards set forth in Sections .6000 through .6200 of this Subchapter.
(d) The site where the facility is located shall:

(1) be approved by the Construction Section prior to the construction of a new facility or the construction of an addition to an existing facility;
(2) be free from noise from railroads, freight yards, main traffic arteries, and schools and children's playgrounds; and
(3) not be exposed to smoke, odors, or dust from industrial plants.

(e) Prior to the construction of a new facility or the construction of an addition or alteration to an existing facility, the governing body shall submit paper copies of the following to the Construction Section for review and approval:

(1) one set of schematic design drawings;
(2) one set of design development drawings; and
(3) one set of construction documents and specifications.

(f) If the North Carolina State Building Code Administrative Code and Policies requires the North Carolina Department of Insurance to review and approve the construction documents and specifications, the governing body shall submit a copy of the construction documents and specifications to the North Carolina Department of Insurance.
(g) The governing body shall submit a functional program that complies with Section 1.2-2 Functional Program of the FGI Guidelines with each submittal cited in Paragraph (e) of this Rule.
(h) The governing body shall:

(1) prepare any component of the safety risk assessment required by Section 1.2-3 Safety Risk Assessment of the FGI Guidelines; and
(2) submit any component of the safety risk assessment prepared to the Construction Section with each submittal cited in Paragraph (e) of this Rule.

(i) In order to maintain compliance with the standards established in this Rule and Sections .6000 through .6200 of this Subchapter, the governing body shall obtain written approval from the Construction Section for any changes made during the construction of the facility in the same manner as set forth in Paragraph (e) of this Rule.
(j) Two weeks prior to the anticipated construction completion date, the governing body shall notify the Construction Section of the anticipated construction completion date in writing either by U.S. Mail at the Division of Health Service Regulation, Construction Section, 2705 Mail Service Center, Raleigh, NC, 27699-2705 or by e-mail at DHSR.Construction.Admin@dhhs.nc.gov.
(k) Construction documents and building construction, including the operation of all building systems, shall be approved in writing by the Construction Section prior to licensure or patient occupancy.
(l) When the Construction Section approves the construction documents and specifications, they shall provide the governing body with an approval letter. The Construction Section's approval of the construction documents and specifications shall expire 12 months after the issuance of the approval letter, unless the governing body has obtained a building permit for construction. If the Construction Section's approval has expired, the governing body may obtain a renewed approval of the construction documents and specifications from the Construction Section as follows:

(1) If the standards established in this Rule and Sections .6000 through .6200 of this Subchapter have not changed, the governing body shall request a renewed approval of the construction documents and specifications from the Construction Section.
(2) If the standards established in this Rule and Sections .6000 through .6200 of this Subchapter have changed, the governing body shall:
    (A) submit revised construction documents and specifications meeting the current standards established in this Rule and Sections .6000 through .6200 of this Subchapter to the Construction Section; and
    (B) obtain written approval of the revised construction documents and specifications from the Construction Section.

(m) Bassinets in a Neonatal Level I nursery as specified in Rule .6228 of this Subchapter shall not be included in a facility's bed capacity; however, no more bassinets shall be placed in service than the number allowed by the requirements set forth in Rule .6228 of this Subchapter. Beds in Neonatal Level II, III, and IV nurseries as specified in Rule .6228 of this Subchapter shall be included in a facility's bed capacity.

History Note: *Authority G.S. 131E-77; 131E-79;*
Eff. January 1, 1996;
Temporary Amendment Eff. March 15, 2002;
Amended Eff. April 1, 2003;
Readopted Eff. April 1, 2019.

10A NCAC 13B .3103 CLASSIFICATION OF MEDICAL FACILITIES

(a) For purpose of this Subchapter the classification of "hospital" shall be restricted to facilities that provide as their functions diagnostic services and medical and nursing care in the treatment of acute stages of illness. On the basis of specialized facilities and services available, the Division shall license each such hospital according to the following medical types:

(1) general acute care hospital;
(2) rehabilitation hospital;
(3) critical access hospital; or
(4) long term acute care hospital which is a hospital which has been classified and certified as a long term care hospital pursuant to 42 CFR Part 412.

(b) All other inpatient medical facilities accepting patients requiring skilled nursing services but which are not operated as a part of any hospital within the above meaning shall be considered to be operating as a nursing home and, therefore, are not subject to licensure pursuant to this Subchapter.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Amended Eff. June 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3104 LENGTH OF LICENSE

Licenses shall remain in effect until one of the following occurs:

(1) Division imposes an administrative sanction which specifies license expiration;
(2) change of ownership;
(3) closure;
(4) change of site;
(5) failure to comply with Rule .3105 of this Section.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3105 STATISTICAL INFORMATION

Utilization data shall be submitted annually upon request by the Division. Forms for collection of this data will be forward to each facility by the Division.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3106 LICENSURE SURVEYS

(a) Prior to the initial issuance of a license to operate a facility, the Division shall conduct a survey to determine compliance with rules promulgated pursuant to G.S. 131E-79.
(b) The Division may conduct an investigation of a complaint in any facility.
(c) Facilities that are accredited through an accrediting body approved pursuant to section 1865(a) of the Social Security Act shall not be subject to routine inspections.
(d) The Division shall survey non-accredited facilities at least once every three years.

History Note: Authority G.S. 131E-79; 131E-80;
Eff. January 1, 1996;
Amended Eff. October 1, 2010;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3107 DENIAL, AMENDMENT OR REVOCATION OF LICENSE

(a) The Department may deny any licensure application upon becoming aware that the applicant is not in compliance with any applicable provision of the Certificate of Need law located in G.S. 131E, Article 9 and the rules adopted under that law.

(b) The Department may amend a license by reducing it from a full license to a provisional license whenever the Department finds that:

(1) the licensee has failed to comply with the provisions of G.S. 131E, Article 5 and the rules promulgated under that article;
(2) there is a probability that the licensee can remedy the licensure deficiencies within a length of time not to exceed the expiration date on the license; and
(3) there is a probability that the licensee will be able thereafter to remain in compliance with the hospital licensure rules for the foreseeable future.

(c) The Department shall also amend a license to provisional status by specifically prohibiting a licensee from providing certain services, for which it has been found to be out of compliance with G.S. 131E, Articles 5 or 9. In all cases the Department shall give the licensee written notice of the amendment of the license. This notice shall be given by registered or certified mail or by personal service and shall set forth:

(1) the length of the provisional license;
(2) the factual allegations;
(3) the statutes and rules alleged to be violated; and
(4) notice of the facility's right to a contested case hearing on the amendment of the license.

(d) The provisional license shall be effective immediately upon its receipt by the licensee and shall be posted in a prominent location, accessible to public view, within the licensed premises in lieu of the full license. The provisional license shall remain in effect until:

(1) the Department restores the licensee to full licensure status;
(2) the Department revokes the licensee's license; or
(3) the end of the licensee's licensure period. If a licensee has a provisional license at the time that the licensee submits a renewal application, the license, if renewed, shall also be a provisional license unless the Department determines that the licensee can be returned to full licensure status. A decision to issue a provisional license is stayed during the pendency of an administrative appeal and the licensee may continue to display its full license during the appeal.

(e) The Department shall revoke a license whenever:

(1) The Department finds that:
    (A) the licensee has failed to comply with the provisions of G.S. 131E, Article 5 and the rules promulgated under that article; and
    (B) it is not probable that the licensee can remedy the licensure deficiencies within a length of time acceptable to the Department; or
(2) The Department finds that:
    (A) The licensee has failed to comply with the provisions of G.S. 131E, Article 5; and
    (B) although the licensee may be able to remedy the deficiencies within a reasonable time, it is not probable that the licensee will be able to remain in compliance with hospital licensure rules for the foreseeable future; or
(3) The Department finds that the licensee has failed to comply with any of the provisions of G.S. 131E, Article 5 and the rules promulgated thereunder that endangers the health, safety or welfare of the patients in the facility.

The issuance of a provisional license is not a procedural prerequisite to the revocation of a license pursuant to Subparagraphs (e)(1), (2) or (3) of this Rule.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3108 SUSPENSION OF ADMISSIONS

(a) The Department may amend a license, pursuant to G.S. 131E-78, by suspending the admission of any new patients to any facility when the conditions in the facility are detrimental to the health or safety of the patients in the facility.

(b) The Department shall notify the facility by registered or certified mail or by personal service of the decision to suspend admissions. Such notice will include:

(1) the period of the suspension;

(2) factual allegations;

(3) citation of statutes and rules alleged to be violated; and

(4) notice of the facility's right to a contested case hearing.

(c) The suspension shall be effective when the notice is served or on the date specified in the notice of suspension, whichever is later. The suspension shall remain effective for the period specified in the notice or until the facility demonstrates to the Department that conditions are no longer detrimental to the health and safety of the patient.

(d) The facility shall not admit new patients during the effective period of the suspension.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3109 PROCEDURE FOR APPEAL

A facility may appeal any decision of the Department to deny, revoke or amend a license or any decision to suspend admissions by making such an appeal in accordance with G.S. 150B.

History Note: Authority G.S. 131E-78; 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3110 ITEMIZED CHARGES

(a) The facility shall provide an itemized list of charges to discharged patients or the facility shall include on patients' bills that are not itemized, notification of the right to request an itemized bill within three years of receipt of the non-itemized bill or so long as the hospital, a collections agency, or other assignee asserts the patient has an obligation to pay the bill.

(b) If requested, the facility shall provide an itemized list of charges to the patient or the patient's representative. This list shall detail in language comprehensible to an ordinary layperson the specific nature of the charges or expenses incurred by the patient.

(c) The itemized listing shall include each specific chargeable item or service in the following service areas:

(1) room rate;

(2) laboratory;

(3) radiology and nuclear medicine;

(4) surgery;

(5) anesthesiology;

(6) pharmacy;

(7) emergency services;

(8) outpatient services;

(9) specialized care;

(10) extended care;

(11) prosthetic and orthopedic appliances; and

(12) professional services provided by the facility.

History Note: Authority G.S. 131E-79; 131E-91;
Eff. January 1, 1996;

Temporary Amendment Eff. May 1, 2014;
Amended Eff. November 1, 2014;
Readopted Eff. April 1, 2020.

10A NCAC 13B .3111 TEMPORARY CHANGE IN BED CAPACITY

(a) A hospital may temporarily increase its bed capacity by up to 10 percent over its licensed bed capacity, as determined by the administrator, by utilizing observational beds for inpatients for a period of no more than 60 consecutive days following approval by the Division of Health Service Regulation.

(b) To qualify for a temporary change in licensed capacity, the hospital census shall be at least 90 percent of its licensed bed capacity, excluding beds that are under renovation or construction, and the hospital must demonstrate conditions requiring the temporary increase that may include but are not limited to the following:

(1) natural disaster;
(2) catastrophic event; or
(3) disease epidemic.

(c) The Division may approve a temporary increase in licensed beds only if:

(1) It is determined that the request has met the requirements of Paragraphs (a) and (b) of this Rule; and
(2) The hospital administrator certifies that the physical facilities to be used are adequate to safeguard the health and safety of patients. However this approval shall be revoked if the Division determines, as a result of a physical site visit, that these safeguards are not adequate to safeguard the health and safety of patients.

History Note: Authority G.S. 131E-79;
Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

SECTION .3200 - GENERAL HOSPITAL REQUIREMENTS

10A NCAC 13B .3201 HOSPITAL REQUIREMENTS

A facility shall have all of the following:

(1) an organized governing body;
(2) a chief executive officer;
(3) an organized medical staff;
(4) an organized nursing staff;
(5) continuous medical services;
(6) continuous nursing services;
(7) permanent on-site facilities for the care of patients 24 hours a day;
(8) a hospital-wide infection control program;
(9) minimum on-site clinical provisions as follows:
    (a) appropriately equipped inpatient care areas;
    (b) nursing care units;
    (c) diagnostic and treatment areas to include on-site laboratory and imaging facilities with the capacity to provide immediate response to patient emergencies;
    (d) pharmaceutical services in compliance with the Pharmacy Laws of North Carolina;
    (e) facilities to assure the sterilization of equipment and supplies;
    (f) medical records services;
    (g) provision for social work services;
    (h) current reference sources to meet staff needs; and
    (i) nutrition services.
(10) minimum supportive capabilities or facilities as follows:
    (a) nutrition and dietetic services;
    (b) scheduled general and preventive maintenance services for building, services and biomedical equipment;
    (c) capability for obtaining police and fire protection, emergency transportation, grounds-keeping, and snow removal;

(d) personnel recruitment, training and continuing education;
(e) business management capability;
(f) short and long-range planning capability;
(g) financial plan to provide continuity of operation under both normal and emergency conditions;
(h) provision for patient, employee, and visitor safety; and
(i) policies for preventive and corrective maintenance including procedures to be followed in the event of a breakdown of essential equipment.

(11) facilities must comply with construction rules in Sections .6000 - .6200 of this Subchapter.
(12) a risk management program as follows:
(a) a specific staff member shall be assigned responsibility for development and administration of the program;
(b) a written policy statement evidencing a current commitment to the risk management program together with written procedures, policies and educational programs applicable to a risk management program which are reviewed at least every three years and updated as necessary;
(c) established lines of communication between the risk management program and other functions relating to quality of patient care, safety, and professional staff performance; and
(d) a written report of the activities of the risk management program shall be annually submitted to the governing body.

(13) a quality assessment and improvement program which provides:
(a) continuous assessment and evaluation of patient care and related services in all services and departments;
(b) a designated individual to coordinate the quality assessment and improvement program who will assist in the establishment of quality assessment and improvement plans and reporting methods for each service and department;
(c) a committee made up of representatives of the medical and nursing staff, administration, and other services or departments as defined by the hospital to coordinate the program, meet at least quarterly and maintain minutes of the meetings and committee activities; and
(d) for each service and department as defined by the hospital to be involved in the continuous assessment, monitoring and evaluation of patient care and related services.

History Note: *Authority G.S. 131E-75; 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3202 ADMISSION AND DISCHARGE

(a) The facility shall provide written admission and discharge, and referral policies.
(b) There shall be on the premises at all times an employee authorized to receive patients and to make arrangements for their disposition.
(c) A patient shall be admitted only under the care of a member of the medical staff meeting the provisions of Section .3700 of this Subchapter.
(d) The facility shall take appropriate precautions to protect the safety and legal rights of patients and employees.
(e) The facility shall maintain a complete and permanent record of all outpatients and inpatients including the date and time of admission and discharge. Effort shall be made to verify the full and true name, address, date of birth, nearest of kin, provisional diagnosis, condition on admission and discharge, referring physicians, attending physician or service.
(f) Facility staff shall provide at the time of admission an identification bracelet, band, or other suitable device for positive identification of each patient.
(g) No mentally competent adult shall be detained by the facility against his will, except as authorized by law.

History Note: *Authority G.S. 131E-75; 131E-79;*
Eff. January 1, 1996;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3203 DISCHARGE PLANNING

(a) Discharge planning shall be an integral part of in-patient hospitalization.

(b) The facility shall have written policies and procedures governing discharge planning. These shall include but need not be limited to the following:

(1) appropriate screening to determine the need for discharge planning;

(2) methods to facilitate the provision of follow-up care;

(3) information to be given to the patient or his family or other persons involved in caring for the patient on matters such as the patient's condition; his health care needs; the amount of activity he should engage in; any necessary medical regimens including drugs, nutrition therapy, appointments or other forms of therapy; sources of additional help from other agencies; and procedures to follow in case of complications; and

(4) procedures for assisting the patient and his family in gaining information regarding financial assistance in paying bills incurred as a result of the hospitalization, including how to receive assistance from the various federal and State government programs.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3204 TRANSFER AGREEMENT

(a) Any facility that does not provide hospital based nursing facility service shall maintain written agreements with institutions offering this kind of care. Such agreements shall provide for the transfer and admission of patients who no longer require the services of the hospital but do require nursing facility services.

(b) A patient shall not be transferred to another medical care facility unless prior arrangements for admission have been made. Clinical records to provide continuity of care shall accompany the patient.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Readopted Eff. April 1, 2020.

10A NCAC 13B .3205 DISCHARGE OF MINOR OR INCOMPETENT

Individuals who cannot legally consent to his or her own care shall be discharged to the custody of parents, legal guardian, person standing in loco parentis, or patient representative pursuant to 42 CFR 483.12(a)(1) herein incorporated by reference with subsequent amendments and editions, unless otherwise directed by the parent or guardian, or court of competent jurisdiction. This regulation may be accessed at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals at no cost. If the parent or guardian directs that discharge be made otherwise, he or she shall so state in writing, and the statement shall become a part of the permanent medical record of the patient.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Readopted Eff. April 1, 2020.

SECTION .3300 - PATIENT'S BILL OF RIGHTS

10A NCAC 13B .3301 PRINCIPLE

It is the purpose of these requirements to promote the interests and well-being of the patients in facilities subject to this Subchapter even in those instances where the interests of the patients may be in opposition to the interests of the facility. The facility has the right to expect the patient to fulfill patient responsibilities as may be stated in the facilities' policies affecting patient care and conduct.

History Note: Authority G.S. 131E-79;

Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3302 MINIMUM PROVISIONS OF PATIENT'S BILL OF RIGHTS

This Rule does not apply to patients in licensed nursing facility beds since these individuals are granted rights pursuant to G.S. 131E-117. A patient in a hospital facility subject to this Rule has the following rights pursuant to 42 CFR 482.13, which is hereby incorporated by reference including subsequent amendments and editions. This regulation can be accessed at https://www.ecfr.gov/cgi-bin/text-idx?SID=e867c7c6cbfeb689406afea7d88e8a80&mc=true&node=pt42.5.482&rgn=div5#se42.5.482_113 at no cost:

(1) A patient has the right to respect, dignity, and comfort.
(2) A patient has the right, upon request, to be given the name of his or her attending physician, the names of all other physicians participating in his or her care, and the names and functions of other health care persons having contact with the patient.
(3) A patient has the right to privacy concerning his or her own medical care program. Case discussion, consultation, examination, and treatment are considered confidential and shall be conducted privately pursuant to 42 CFR 482.13(c)(1):
(4) A patient has the right to know what facility rules and regulations apply to his or her conduct as a patient.
(5) A patient has the right to expect emergency procedures to be implemented without delay.
(6) A patient has the right to quality care and professional standards that are maintained and reviewed.
(7) A patient has the right to information in laymen's terms, concerning his or her diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. When it is not possible or medically advisable to give such information to the patient, the information shall be given on his or her behalf to the patient's designee.
(8) Except for emergencies, a physician must obtain informed consent prior to the start of any procedure or treatment.
(9) A patient has the right to be advised when a physician is considering the patient as a part of a medical care research program or donor program. Informed consent shall be obtained prior to participation in such a program. The patient or legally responsible party may refuse to continue in any program that he or she has previously given informed consent. An Institutional Review Board (IRB) may waive or alter the informed consent requirement if it reviews and approves a research study in accordance with federal regulations for the protection of human research subjects including U.S. Department of Health and Human Services (HHS) regulations under 45 CFR Part 46 and U.S. Food and Drug Administration (FDA) regulations under 21 CFR Parts 50 and 56. 45 CFR Part 46 and 21 CFR Parts 50 and 56 are incorporated by reference, including subsequent amendments and editions. These regulations may be accessed at https://www.hhs.gov/ohrp/regulations-and-policy/regulations/common-rule/index.html at no cost. For any research study proposed for conduct under an FDA "Exception from Informed Consent Requirements for Emergency Research" or an HHS "Emergency Research Consent Waiver" that waives informed consent but community consultation and public disclosure about the research are required, any facility proposing to be engaged in the research study shall also verify that the proposed research study has been registered with the North Carolina Medical Care Commission. When the IRB has authorized the start of the community consultation process required for emergency research, but before the beginning of that process, notice of the proposed research study shall be provided to the North Carolina Medical Care Commission. The notice shall include:
    (a) the title of the research study;
    (b) a description of the research study, including a description of the population to be enrolled;
    (c) a description of the planned community consultation process, including proposed meeting dates and times;
    (d) instructions for opting out of the research study; and
    (e) contact information including mailing address and phone number for the IRB and the principal investigator.

    The Medical Care Commission may publish all or part of the above information in the North Carolina Register, in accordance with 26 NCAC 02C .0307, and may require the institution

proposing to conduct the research study to attend a public meeting convened by a Medical Care Commission member in the community where the proposed research study is to take place to present and discuss the study or the community consultation process proposed.

(10) A patient has the right to refuse any drugs, treatment or procedure offered by the facility, and a physician shall inform the patient of his or her right to refuse any drugs, treatment or procedures and of the medical consequences of the patient's refusal of any drugs, treatment or procedure.

(11) A patient has the right to assistance in obtaining consultation with another physician at the patient's request and expense.

(12) A patient has the right to medical and nursing services without discrimination based upon race, color, religion, sex, sexual orientation, gender identity, national origin or source of payment.

(13) A patient who does not speak English shall have access to an interpreter.

(14) A patient or his or her designee has the right to have all records pertaining to his or her medical care treated as confidential except as otherwise provided by law or third party contractual arrangements. A patient's access to medical records may be restricted by the patient's attending physician. If the physician restricts the patient's access to information in the patient's medical record, the physician shall record the reasons on the patient's medical record. Access shall be restricted only for medical reason. A patient's designee shall have access to the information in the patient's medical records even if the attending physician restricts the patient's access to those records.

(15) A patient has the right not to be awakened by hospital staff unless it is medically necessary.

(16) The patient has the right to be free from duplication of medical and nursing procedures as determined by the attending physician.

(17) The patient has the right to medical and nursing treatment that avoids unnecessary physical and mental discomfort.

(18) When medically permissible, a patient may be transferred to another facility only after he or his next of kin or other legally responsible representative has received complete information and an explanation concerning the needs for and alternatives to such a transfer. The facility that the patient is to be transferred must first have accepted the patient for transfer.

(19) The patient has the right to examine and receive a detailed explanation of his bill.

(20) The patient has a right to information and counseling on the availability of known financial resources for his health care.

(21) A patient has the right to be informed upon discharge of his or her continuing health care requirements following discharge and the means for meeting them.

(22) A patient shall not be denied the right of access to an individual or agency who is authorized to act on his or her behalf to assert or protect the rights set out in this Section.

(23) A patient has the right to be informed of his rights at the earliest possible time in the course of his or her hospitalization.

(24) A patient has the right to designate visitors who shall receive the same visitation privileges as the patient's immediate family members, regardless of whether the visitors are legally related to the patient.

History Note: *Authority G.S. 131E-75; 131E-79; 143B-165;*
RRC Objection due to ambiguity Eff. July 13, 1995;
Eff. January 1, 1996;
Temporary Amendment Eff. April 1, 2005;
Amended Eff. January 1, 2011; May 1, 2008; November 1, 2005;
Readopted Eff. April 1, 2020.

10A NCAC 13B .3303 PROCEDURE

(a) The facility shall develop and implement procedures to inform patients of his or her rights. Copies of the facilities' Patient's Bill of Rights shall be made available through one of the following ways:

(1) locations posted in a public place in the facility in addition to copies available upon request; or

(2) provided a copy to each patient or responsible party upon admission or as soon after admission as is feasible.

(b) The address and telephone number of the Acute and Home Care Licensure and Certification Section in the Department responsible for the enforcement of the provisions of this Rule shall be posted.

(c) The facility shall adopt procedures to ensure a comprehensive investigation of violations of patients' rights and to ensure their enforcement pursuant to 42 CFR 483.12(a)(2) herein incorporated by reference including subsequent amendments and editions. This regulation may be accessed at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals at no cost. These procedures shall ensure that:

(1) a system is established to identify formal written complaints;
(2) written complaints are recorded and investigated;
(3) investigation and resolution of complaints shall be conducted; and
(4) disciplinary and education procedures shall be developed for members of the hospital and medical staff who are noncompliant with facility policies.

(d) The Division shall investigate or refer to other State agencies all complaints within the jurisdiction of the rules in this Subchapter.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Readopted Eff. April 1, 2020.

SECTION .3400 - SUPPLEMENTAL RULES FOR THE LICENSURE OF CRITICAL ACCESS HOSPITALS

10A NCAC 13B .3401 SUPPLEMENTAL RULES

The rules of this Section pertain only to designated Critical Access Hospitals in accordance with 42 CFR 485 Subpart F. The general requirements of this Subchapter shall apply to such facilities except where they are specifically waived or modified by the rules of this Section.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Amended Eff. November 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3402 DEFINITIONS

The following definitions shall apply throughout this Section, unless context otherwise clearly indicates to the contrary:

(1) "Available" means provided directly by the facility or by written agreement with a qualified provider of the service within one hour driving time.
(2) "Critical Access Hospital" means a facility designated by the North Carolina Office of Rural Health in accordance with 42 CFR 485 Subpart F.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Amended Eff. November 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017;
Amended Eff. October 1, 2019.

10A NCAC 13B .3403 LICENSURE APPLICATION
10A NCAC 13B .3404 FEDERALLY CERTIFIED PRIMARY CARE HOSPITAL

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Repealed Eff. November 1, 2004.

10A NCAC 13B .3405 DESIGNATED CRITICAL ACCESS HOSPITALS

The requirements of 10A NCAC 13B shall apply to Critical Access Hospitals with the following modifications:

(1) Autopsy facilities required in Rule .4907 of this Subchapter are not required provided that the facility has in effect a written agreement with another facility meeting Rule .4907 of this Subchapter for providing autopsy services.

(2) Radiological services required in Section .4800 and Rule .6210 of this Subchapter are not required provided that the facility has a written agreement with another licensed facility meeting the requirements of Section .4800 and Rule .6210 of this Subchapter which makes radiological service available.

(3) Emergency services required in Rules .4102-.4110 of this Subchapter are not required. Emergency response capability set forth in Rule .4101 of this Subchapter shall be provided. Medical staff shall require that facility personnel are capable of initiating life-saving measures at a first-aid level of response for any patient or person in need of such services. This shall include:

(a) Establishing protocols or agreements with any facility providing emergency services;

(b) Initiating basic cardio-pulmonary resuscitation according to the American Red Cross or American Heart Association standards;

(c) Availability of intravenous fluids and supplies required to establish intravenous access; and

(d) Availability of first-line emergency drugs as specified by the medical staff.

(4) Anesthesia services required in Section .4600 of this Subchapter are not required in hospitals not offering outpatient surgery services.

(5) Food services required in Section .4700 of this Subchapter shall be provided for inpatients directly or made available through contractual arrangements.

(6) "Observation bed" as defined in Rule .3001(32) of this Subchapter does not apply. For purposes of this Section, "Observation bed" means a bed used for no more than 48-hours, to evaluate and determine the condition and disposition of a patient and is not considered a part of the hospital's licensed bed capacity.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Amended Eff. November 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

SECTION .3500 - GOVERNANCE AND MANAGEMENT

10A NCAC 13B .3501 GOVERNING BODY

(a) The governing body, owner, or the person or persons designated by the owner as the governing body shall be responsible for ensuring that the objectives specified in the facility's governing documents, such as the charter or resolution, are attained.

(b) The governing body shall be the final authority for decisions for which the facility administration, the medical staff, and the facility personnel are directly or indirectly responsible within the facility.

(c) A local advisory board shall be established to provide non-binding advice to the governing body regarding the health, safety, and welfare of the community, if the facility is owned by an organization or persons outside of North Carolina. A local advisory board shall include members from the county where the facility is located.

History Note: *Authority G.S. 131E-75; 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017;
Amended Eff. July 1, 2020.

10A NCAC 13B .3502 REQUIRED FACILITY BYLAWS, POLICIES, RULES, AND REGULATIONS

(a) The governing body shall adopt written bylaws, policies, rules, and regulations in accordance with all requirements contained in this Subchapter and in accordance with the community responsibility of the facility. The written bylaws, policies, rules, and regulations shall:

(1) state the objectives;

(2) describe the powers and duties of the governing body officers and committees and the responsibilities of the chief executive officer;
(3) state the qualifications for governing body membership, the procedures for selecting members, and the terms of service for members, officers and committee chairmen;
(4) describe the authority delegated to the chief executive officer and to the medical staff. No assignment, referral, or delegation of authority by the governing body shall relieve the governing body of its responsibility for the conduct of the facility. The governing body shall retain the right to rescind any such delegation;
(5) require governing body approval of the bylaws of any auxiliary organizations established by the facility;
(6) require the governing body to review and approve the bylaws of the medical staff;
(7) establish procedures for processing and evaluating the applications for medical staff membership and for the granting of clinical privileges;
(8) establish a procedure for implementing, disseminating, and enforcing a Patient's Bill of Rights as set forth in Rule .3302 of this Subchapter and in compliance with G.S. 131E-117; and
(9) require the governing body to institute procedures to provide for:
    (A) orientation of newly elected governing body members to board functions and procedures;
    (B) the development of procedures for periodic reexamination of the relationship of the governing body to the total facility community; and
    (C) the recording of minutes of all governing body and executive committee meetings and the dissemination of those minutes, or summaries thereof, after the governing body and executive committee meetings to all members of the governing body.

(b) The governing body shall provide written policies and procedures to assure billing and collection practices in accordance with G.S. 131E-91. These policies and procedures shall include:
(1) a financial assistance policy as defined in G.S. 131E-214.14(b)(3);
(2) how a patient may obtain an estimate of the charges for the statewide 100 most frequently reported Diagnostic Related Groups (DRGs), where applicable, 20 most common outpatient imaging procedures, and 20 most common outpatient surgical procedures. The policy shall require that the information be provided to the patient in writing, either electronically or by mail, within three business days;
(3) how a patient or patient's representative may dispute a bill;
(4) issuance of a refund within 45 days of the patient receiving notice of the overpayment when a patient has overpaid the amount due to the facility;
(5) providing written notification to the patient or patient's representative at least 30 days prior to submitting a delinquent bill to a collections agency;
(6) providing the patient or patient's representative with the facility's charity care and financial assistance policies, if the facility is required to file a Schedule H, federal form 990;
(7) the requirement that a collections agency, entity, or other assignee obtain written consent from the facility prior to initiating litigation against the patient or patient's representative;
(8) a policy for handling debts arising from the provision of care by the facility involving the doctrine of necessaries, in accordance with G.S. 131E-91(d)(5); and
(9) a policy for handling debts arising from the provision of care by the facility to a minor, in accordance with G.S. 131E-91(d)(6).

(c) The governing body shall ensure that the bylaws, rules, and regulations of the medical staff and the bylaws, rules, policies, and regulations of the facility shall not be in conflict.
(d) The written policies, rules, and regulations shall be reviewed every three years, revised as necessary, and dated to indicate when last reviewed or revised.
(e) To qualify for licensure or license renewal, each facility must provide to the Division, upon application, an attestation statement in a form provided by the Division verifying compliance with the requirements of this Rule.
(f) On an annual basis, on the license renewal application provided by the Division, the facility shall provide to the Division the direct website address to the facility's financial assistance policy. This Paragraph applies only to facilities required to file a Schedule H, federal form 990.

History Note: Authority G.S. 131E-79; 131E-91; 131E-214.8; 131E-214.13(f); 131E-214.14;
Eff. January 1, 1996;
Temporary Amendment Eff. May 1, 2014;

Amended Eff. November 1, 2014;
Readopted Eff. July 1, 2020.

10A NCAC 13B .3503 FUNCTIONS

(a) The governing body shall:

(1) provide management, physical resources, and personnel determined by the governing body to be required to meet the needs of patients for treatment as authorized by the facility's license;
(2) require facility administration to establish a quality control mechanism that includes a risk management component and an infection control program;
(3) formulate short-range and long-range plans as defined in the facility bylaws, policies, rules, and regulations;
(4) conform to all applicable State and federal laws, rules, and regulations, and applicable local ordinances;
(5) provide for the control and use of the physical and financial resources of the facility;
(6) review the annual audit, budget, and periodic reports of the financial operations of the facility;
(7) consider the recommendation of the medical staff in granting and defining the scope of clinical privileges to individuals in accordance with medical staff bylaws requirements for making such recommendations and the facility bylaws established by the governing body for the review and final determination of such recommendations;
(8) require that applicants be informed of the disposition of their application for medical staff membership or clinical privileges in accordance with the facility bylaws established by the governing body, after an application has been submitted;
(9) review and approve the medical staff bylaws, rules, and regulations;
(10) delegate to the medical staff the authority to:
   (A) evaluate the professional competence of medical staff members and applicants for medical staff membership and clinical privileges; and
   (B) recommend to the governing body initial medical staff appointments, reappointments, and assignments or curtailments of privileges;
(11) require that resources be made available to address the emotional and spiritual needs of patients either directly or through referral or arrangement with community agencies;
(12) maintain communication with the medical staff which may be established through:
   (A) meetings with the executive committee of the medical staff;
   (B) service by the president of the medical staff as a member of the governing body with or without a vote;
   (C) appointment of individual medical staff members to the medical review committee; or
   (D) a joint conference committee that will be a committee of the governing body and the medical staff composed of equal representatives of each of the governing body, the chairman of the board or designee, the medical staff, and the chief of the medical staff or designee, respectively;
(13) require the medical staff to establish controls that are designed to provide that standards of ethical professional practices are met;
(14) provide administrative staff support to facilitate utilization review and infection control within the facility, to support quality control and any other medical staff functions required by this Subchapter or by the facility bylaws;
(15) meet the following disclosure requirements:
   (A) provide data required by the Division;
   (B) disclose the facility's average daily inpatient charge upon request of the Division; and
   (C) disclose the identity of persons owning five percent or more of the facility as well as the facility's officers and members of the governing body upon request;
(16) establish a procedure for reporting the occurrence and disposition of allegations of abuse or neglect of patients and incidents involving quality of care or physical environment at the facility. These procedures shall require that:
   (A) incident reports are analyzed and summarized by a designated party; and
   (B) corrective action is taken based upon the analysis of incident reports;

(17) in a facility with one or more units, or portions of units, however described, utilized for psychiatric or substance abuse treatment, adopt policies implementing the provisions of G.S. 122C, Article 3, and Article 5, Parts, 2, 3, 4, 5, 7, and 8;
(18) develop arrangements for the provision of extended care and other long-term healthcare services. Such services shall be provided in the facility or by outside resources through a transfer agreement or referrals;
(19) provide and implement a written plan for the care or for the referral, or both, of patients who require mental health or substance abuse services while in the facility;
(20) develop a conflict of interest policy which shall apply to all governing body members and facility administration. All governing body members shall execute a conflict of interest statement; and
(21) conduct direct consultations with the medical staff at least twice during the year.

(b) For the purposes of this Rule, "direct consultations" means the governing body, or a subcommittee of the governing body, meets with the leader(s) of the medical staff(s), or his or her designee(s) either face-to-face or via a telecommunications system permitting immediate, synchronous communication.

(c) The direct consultations shall consist of discussions of matters related to the quality of medical care provided to the hospital's patients, including quality matters arising out of the following:
(1) the scope and complexity of services offered by the facility;
(2) specific clinical populations served by the facility;
(3) limitations on medical staff membership other than peer review or corrective action in individual cases;
(4) circumstances relating to medical staff access to a facility resource; or
(5) any issues of patient safety and quality of care that a hospital's quality assessment and performance improvement program might identify as needing the attention of the governing body in consultation with the medical staff.

(d) For the purposes of this Rule, "specific clinical populations" includes those individuals who may be treated at the facility by the medical staff in place at the time of the consultation.

History Note: Authority G.S. 131E-14.2; 131E-79; 42 CFR 482.12; 42 CFR 482.22;
Eff. January 1, 1996;
Readopted Eff. July 1, 2020.

SECTION .3600 - MANAGEMENT AND ADMINISTRATION OF OPERATIONS

10A NCAC 13B .3601 CHIEF EXECUTIVE OFFICER

(a) The governing body shall designate a chief executive officer whose qualifications, authority, responsibilities and duties shall be defined in a written statement adopted by the governing body.

(b) The chief executive officer shall be the designated representative of the governing body and may be given any one or more or all of the responsibilities set out in Rule .3602 of this Section.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3602 RESPONSIBILITIES

The governing body shall adopt written policies, rules, and regulations that specify the officer or officers that shall:
(1) act for the chief executive officer in his absence;
(2) manage the facility consonant with its expressed aims and policies;
(3) attend meetings of the governing body and appropriate meetings of the medical staff;
(4) implement policies adopted by the governing body for the operation of the facility;
(5) organize the administrative functions of the facility, delegate duties and establish formal means of accountability on the part of subordinates;
(6) establish such facility departments as are indicated, provide for departmental and interdepartmental meetings and attend or be represented at such meetings, and appoint hospital departmental representatives to medical staff committees where appropriate or when requested to do so by the medical staff;

(7) appoint the heads of administrative departments;
(8) report to the governing body and to the medical staff on the overall activities of the facility as well as on appropriate federal, State and local developments that affect health care in the facility;
(9) review the annual audit of the financial operations of the facility and acting upon recommendations therein;
(10) provide fiscal planning and financial management of the facility including the provision of annual budgets and periodic financial status reports to the governing board;
(11) develop in cooperation with the departmental heads and other appropriate staff, an overall organizational plan for the facility which will coordinate the functions, services and departments of the facility, when possible; and
(12) require that the agreements with service providers, such as laundry, laboratory and imaging, specifically indicate that compliance will be maintained with applicable State rules as would apply to the same services if provided directly by the facility.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3603 PERSONNEL POLICIES AND PRACTICES

The facility shall develop, establish and maintain personnel policies and practices which support sound patient care. The policies shall be in writing and made available to all employees, and they shall be reviewed periodically but no less often than once every three years. The date of the most recent review shall be indicated on the written policies. A procedure shall be established for notifying employees of changes in the established personnel policies.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3604 JOB DESCRIPTIONS

The facility shall develop and make available to the employee a written job description for each type of job in the facility, including the chief executive officer and heads of departments. Each job description shall include a written description of the education, experience, license, certification, or other qualifications required for the position.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3605 PERSONNEL RECORDS

(a) The facility shall maintain accurate and complete personnel records for each facility employee during the term of employment and for two years thereafter. The chief executive officer may designate an individual to carry out this assignment.
(b) Personnel records shall be maintained under such conditions as may be required by state or federal law and shall contain at least the following:
(1) information regarding the employee's education, training and experience and clinical competence, including, if applicable, professional licensure status and license number, sufficient to verify the employee's qualifications for the job for which he is employed. Such information shall be kept current. Applicants for positions requiring a licensed person shall be hired only after obtaining verification of their licenses from the appropriate board;
(2) current information relative to periodic work performance evaluations;
(3) records of such pre-employment health examinations and of subsequent health services rendered to the employees as are necessary to determine that all facility employees are physically able to perform the essential duties of their positions.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3606 EDUCATION PROGRAMS

The facility shall provide new employee orientation and continuing education programs for all employees to maintain the skills necessary for the performance of their duties and learn new developments in health care. Records shall be maintained of all orientation and educational programs, and of the participants.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3607 PERSONNEL HEALTH REQUIREMENTS

Employees shall have pre-employment medical examinations and interim examinations in accordance with medical criteria established by the facility.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3608 INSURANCE

The governing board shall have in place an insurance program which provides for the protection of the physical and financial resources of the facility.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3609 AUDIT OF FINANCIAL OPERATIONS

An audit of the financial operations of the facility shall be performed by a public accountant at least once a year.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

SECTION .3700 - MEDICAL STAFF

10A NCAC 13B .3701 GENERAL PROVISIONS

(a) The facility shall have a self-governed medical staff that shall be accountable to the governing body for the quality of care provided by individuals with medical staff membership and clinical privileges to provide medical services in the facility. Facility policy shall provide that individuals with clinical privileges shall perform only services within the scope of individual privileges granted.

(b) Minutes required by the rules of this Section shall reflect all transactions, conclusions, and recommendations of meetings. Minutes shall be prepared and retained in accordance with a policy established by the facility and medical staff, and available for inspection by members of the medical staff and governing body, respectively, unless such minutes include confidential peer review information that is not accessible to others in accordance with any law protecting the confidentiality.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;

Readopted Eff. July 1, 2020.

10A NCAC 13B .3702 ESTABLISHMENT

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Repealed Eff. July 1, 2020.

10A NCAC 13B .3703 APPOINTMENT

(a) The governing body may grant, deny, renew, modify, suspend, or terminate medical staff membership and clinical privileges after consideration of the recommendation made by the medical staff in accordance with the bylaws established by the medical staff and approved by the governing body for making such recommendations, and the facility bylaws established by the governing body for review and final determination of such recommendations.
(b) Review of an applicant for medical staff membership and the granting of clinical privileges shall follow procedures set forth in the bylaws, rules, and regulations of the medical staff. These procedures shall require the following:

(1) a signed application for medical staff membership, specifying date of birth, year and school of graduation, date of licensure, statement of postgraduate or special training and experience, and a statement of the scope of the clinical privileges sought by the applicant;
(2) verification by the facility of the applicant's qualifications as stated in the application, including any required continuing education; and
(3) written notice to the applicant from the governing body regarding appointment or reappointment, which specifies the approval or denial of clinical privileges and the scope of the privileges if granted.

(c) Members of the medical staff and others granted clinical privileges in the facility shall hold current licenses to practice in North Carolina.
(d) Medical staff appointments shall be reviewed at least once every two years by the medical staff in accordance with the bylaws established by the medical staff and approved by the governing body, and shall be followed with recommendations made to the governing body for review and a final determination.
(e) The facility shall maintain a file containing performance information for each medical staff member. Representatives of the Division shall have access to these files in accordance with, and subject to the limitations and restrictions set forth in, G.S. 131E-80; however, to the extent that the same includes confidential medical review information, such information shall be reviewable and confidential in accordance with G.S. 131E-80(d) and other applicable law.
(f) Minutes shall be taken and maintained of all meetings of the medical staff and governing body that concern the granting, denying, renewing, modifying, suspending or terminating of clinical privileges.

History Note: *Authority G.S. 131E-79; 42 CFR 482.12(a)(10); 42 CFR 482.22(a)(1);*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017;
Amended Eff. July 1, 2020.

10A NCAC 13B .3704 ESTABLISHMENT AND CATEGORIES OF MEDICAL STAFF MEMBERSHIP

(a) The medical staff shall be established in accordance with the bylaws of the facility and organized in accordance with the bylaws, rules, and regulations of the medical staff. After considering the recommendations of the medical staff, the governing body of the facility may, in accordance with G.S. 131E-85, grant medical staff membership and clinical privileges to qualified, licensed practitioners in accordance with their training, experience, and demonstrated competence and judgment in accordance with the medical staff bylaws, rules, and regulations.
(b) Every facility shall have an active medical staff, as defined by the medical staff bylaws, rules, and regulations, to deliver medical services within the facility and to administer medical staff functions. The members of the active medical staff shall be eligible to vote at medical staff meetings and to hold medical staff office positions as determined by the medical staff bylaws, rules, and regulations and shall be responsible for recommendations made to the governing body regarding the organization and administration of the medical staff. Medical staff office positions shall be determined in the medical staff bylaws, rules, and regulations.

(c) The active medical staff may establish other categories for membership in the medical staff. These categories for membership shall be identified and defined in the medical staff bylaws. Examples of membership categories include:

(1) active medical staff;
(2) associate medical staff;
(3) courtesy medical staff;
(4) temporary medical staff;
(5) consulting medical staff;
(6) honorary medical staff; or
(7) other staff classifications.

The medical staff bylaws shall describe the authority, duties, privileges, and voting rights for each membership category consistent with applicable law, rules, and regulations and requirements of facility accrediting bodies.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Readopted Eff. July 1, 2020.

10A NCAC 13B .3705 MEDICAL STAFF BYLAWS, RULES, AND REGULATIONS

(a) The active medical staff shall develop and adopt, subject to the approval of the governing body, a set of bylaws, rules, and regulations to establish a framework for self-governance of medical staff activities and accountability to the governing body.

(b) The medical staff bylaws, rules, and regulations shall provide for the following:

(1) organizational structure;
(2) qualifications for medical staff membership;
(3) procedures for granting or renewing, denying, modifying, suspending, and revoking clinical privileges;
(4) procedures for disciplinary or corrective actions;
(5) procedures for fair hearing and appellate review mechanisms for denying, modifying, suspending, and revoking clinical privileges;
(6) composition, functions and attendance of standing committees;
(7) policies for completion of medical records;
(8) formal liaison between the medical staff and the governing body;
(9) methods developed to formally verify that each medical staff member on appointment or reappointment agrees to abide by current medical staff bylaws, rules, and regulations, and the facility bylaws, rules, policies, and regulations;
(10) procedures for participation in quality assurance functions by medical staff members;
(11) the process for the selection and election and removal of medical staff officers; and
(12) procedures for the proposal, adoption, and amendment, and approval of medical staff bylaws, rules, and regulations.

(c) Neither the medical staff, the governing body, nor the facility administration may unilaterally amend the medical staff bylaws, rules, and regulations.

(d) Neither the medical staff, the governing body, nor the facility administration may waive any provision of the medical staff bylaws, rules, and regulations, except in an emergency circumstance. For purposes of this Rule, an "emergency circumstance" means a situation of urgency that justifies immediate action and when there is not sufficient time to follow the applicable provisions and procedures of the medical staff bylaws. Examples of an emergency circumstance include an immediate threat to the life or health of an individual or the public, a natural disaster, or a judicial or regulatory order. The duration of a waiver permitted by this Rule will be only so long as the emergency circumstance exists.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Readopted Eff. July 1, 2020.

10A NCAC 13B .3706 ORGANIZATION AND RESPONSIBILITIES OF THE MEDICAL STAFF

(a) The medical staff shall be organized to accomplish its required functions as established by the governing body and medical staff bylaws, rules, and regulations and provide for the election or appointment of its own officers.

(b) There shall be an executive committee, or its equivalent, which represents the medical staff, that has responsibility for the effectiveness of all medical activities of the staff, and that acts for the medical staff.
(c) The following functions shall be performed by the medical staff:

(1) credentialing review;
(2) medical records review;
(3) drug utilization review;
(4) radiation safety review;
(5) blood usage review;
(6) bylaws review;
(7) medical review;
(8) peer review; and
(9) recommendations for discipline or corrective action of medical staff members.

(d) The medical staff shall ensure that minutes are prepared for each medical staff, departmental, and committee meeting.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Readopted Eff. July 1, 2020.

10A NCAC 13B .3707 MEDICAL ORDERS

(a) No medication or treatment shall be administered or discontinued except in response to the order of a member of the medical staff in accordance with policies, rules, and regulations established by the facility and medical staff and as provided in Paragraph (f) of this Rule.
(b) Such orders shall be dated and recorded directly in the patient medical record. A method shall be established to safeguard against fraudulent recordings.
(c) All orders for medication or treatment shall be authenticated according to medical staff and facility policies, rules, or regulations. The order shall be taken by personnel qualified by medical staff bylaws, rules, and regulations, and shall include the date, time, and name of persons who gave the order, and the full signature of the person taking the order.
(d) The names of drugs shall be recorded in full and not abbreviated except where approved by the active medical staff.
(e) The active medical staff shall establish a written policy in conjunction with the pharmacy committee or its equivalent for all medications not specifically prescribed as to time or number of doses to be automatically stopped after a reasonable time limit, but no more than 14 days. The prescriber shall be notified according to established policies and procedures at least 24 hours before an order is automatically stopped.
(f) For patients who are under the continuing care of an out-of-state physician but are temporarily located in North Carolina, a facility may process the out-of-state physician's prescriptions or orders for diagnostic or therapeutic studies which maintain and support the patient's continued program of care, where the authenticity and currency of the prescriptions or orders can be verified by the physician who prescribed or ordered the treatment requested by the patient, and where the facility verifies that the out-of-state physician is licensed to prescribe or order the treatment.

History Note: Authority G.S. 131E-75; 131E-79;
Eff. January 1, 1996;
Amended Eff. April 1, 2005; August 1, 1998;
Readopted Eff. July 1, 2020.

10A NCAC 13B .3708 MEDICAL STAFF RESPONSIBILITIES FOR QUALITY IMPROVEMENT REVIEW

(a) The medical staff shall have in effect a system to review care provided at the facility by members of the medical staff, to assess quality, to provide a process for quality improvement, and to monitor the outcome of quality improvement activities.
(b) The medical staff shall establish criteria for the evaluation of the quality of care.
(c) The facility shall have a written plan that generates reports to permit identification of patient care problems and that establishes a system to use this data to document and identify interventions. The plan shall be approved by the medical staff, facility administration, and the governing body.

(d) The medical staff shall establish a policy to maintain a review process of the care provided by members of the medical staff to all patients in every medical department of the facility. The medical staff shall have a policy to schedule meetings to examine the review process and results. The review process shall include both practitioners and allied health professionals from the medical staff.
(e) Minutes shall be prepared for all meetings reviewing quality improvement and shall reflect all of the transactions, conclusions, and recommendations of the meeting.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017;
Amended Eff. July 1, 2020.

SECTION .3800 - NURSING SERVICES

10A NCAC 13B .3801 NURSE EXECUTIVE

(a) Whether the facility utilizes a centralized or decentralized organizational structure, a nurse executive shall be responsible for the coordination of nursing organizational functions.
(b) A nurse executive shall develop facility wide patient care programs, policies, and procedures that describe how the nursing care needs of patients are assessed, met, and evaluated.
(c) The nurse executive shall develop and adopt, subject to the approval of the facility, a set of administrative policies and procedures to establish a framework to accomplish required functions as required in Paragraph (e) of this Rule.
(d) There shall be scheduled meetings every 60 days of the members of the nursing staff to evaluate the quality and efficiency of nursing services. Minutes of these meetings shall be maintained.
(e) The nurse executive shall be responsible for:

(1) the development of a written organizational plan which describes the levels of accountability and responsibility within the nursing organization;
(2) planning for and the evaluation of the delivery of nursing care system;
(3) establishment of a mechanism to validate qualifications, knowledge, and skills of nursing personnel;
(4) provision of orientation and educational opportunities related to expected nursing performance and maintenance of records pertaining thereto;
(5) implementation of a system for performance evaluation;
(6) provision of nursing care services in conformance with G.S. 90-171.20(7) and G.S. 90-171.20(8);
(7) assignment of nursing staff to clinical or managerial responsibilities based upon educational preparation, in conformance with licensing laws and an assessment of current competence; and
(8) staffing nursing units with personnel in accordance with a written plan of care to meet the needs of the patients.

History Note: *Authority G.S. 143B-165;*
Eff. January 1, 1996;
Readopted Eff. August 1, 2023.

10A NCAC 13B .3802 NURSING STAFF

(a) Licensed nurses and other nursing personnel shall be qualified by training, education, experience and demonstrated abilities to provide nursing care within their scope of practice.
(b) Staffing schedules which reflect personnel assignment by date and service unit shall be kept on file for at least three years by hospital management.
(c) The facility shall establish policies for the provision of services for all contractual agreement personnel that include at a minimum the following:

(1) verification of licensure or certification by the appropriate occupational board;
(2) delivery and documentation of care;
(3) participation on interdisciplinary care planning activities; and
(4) supervision of contractual agreement personnel.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3803 NURSING POLICIES AND PROCEDURES

(a) Nursing policies and procedures shall be available to the nursing staff in each nursing care unit and service area and shall include the following:

(1) method of noting diagnostic and therapeutic orders;
(2) method of assigning nursing care of patients;
(3) infection control measures;
(4) patient safety measurers; and
(5) method of implementing orders for medication or treatment.

(b) Each unit shall have relevant clinical reference materials available. The following shall be provided to each unit:

(1) a facility formulary or comparable drug reference;
(2) a policy and procedure manual; and
(3) a medical dictionary.

(c) The facility shall provide a program of inservice education which shall be maintained and documented for all nursing staff personnel. Annual inservices shall include infection control measures, cardiopulmonary resuscitation and fire and safety.

(d) Nursing care policies and procedures shall be reviewed at least every three years by the nursing staff and facility management and revised as necessary. They shall include the date to indicate the time of the most recent review or revision.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3804 PATIENT CARE

(a) Each patient's need for nursing care related to his or her admission shall be determined by a registered nurse. Patient needs shall be reassessed when warranted by the patient's condition.

(b) Each patient's nursing care shall be based upon assessed needs and shall be coordinated with the therapies of other disciplines.

(c) The patient's medical record shall include documentation of:

(1) the initial assessment and reassessments of patient clinical status;
(2) patient care needs;
(3) interventions performed to meet the patient's nursing care needs;
(4) implementation of physician's orders;
(5) the nursing care provided; and
(6) the patient's response to, and the outcomes of, the care provided.

(d) Each plan of care shall be initiated within 24 hours of admission. The plan of care shall become a part of the clinical record.

(e) The nursing care plan shall be readily available to all physicians and facility personnel involved with the care of the patient.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

SECTION .3900 - MEDICAL RECORD SERVICES

10A NCAC 13B .3901 ORGANIZATION

(a) The facility shall establish a medical record service. It shall be directed, staffed and equipped to accurately process, index, and file all medical records. Orientation, on-the-job training and inservice programs for medical records personnel shall be provided.
(b) The medical record service shall be equipped to enable its personnel to maintain medical records so that they are readily accessible and secure from unauthorized use.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3902 MANAGER

(a) The medical records service shall be directed and supervised by a qualified medical records manager. If the manager is not a registered record administrator or an accredited records technician, the facility shall retain a person with those qualifications on a part-time or consulting basis.
(b) The manager of the medical record service shall advise, administer, supervise and perform work involved in the development, analysis, maintenance and use of medical records and reports.
(c) Where the manager is employed on a part-time or consulting basis, he or she shall organize the department, train the regular personnel and make periodic visits to the facility. The manager shall evaluate the records and the operation of the service and document the visits by written reports. A written contract specifying his or her duties and responsibilities shall be kept on file and made available for inspection by the Division's surveyor.
(d) The manager of the medical record service shall maintain a system of identification and filing to facilitate the prompt location of medical record of any patient.
(e) The manager of the medical records service shall store medical records in such a manner as to provide protection from loss, damage, and unauthorized access.

History Note: Authority G.S. 131E-79;
RRC Objection due to lack of Statutory Authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3903 PRESERVATION OF MEDICAL RECORDS

(a) The manager of the medical records service shall maintain medical records that were created when the patient was an adult, whether original, computer media, or digital archived for 11 years following the discharge of an adult patient.
(b) The manager of medical records shall maintain medical records that were created when the patient was a minor, whether original, computer media, or digital archived, until the patient's 30th birthday. If a minor patient is readmitted as an adult, the manager of the medical records shall maintain medical records according to Paragraph (a) of this Rule.
(c) If a hospital discontinues operation, its management shall make known to the Division where its records are stored. Records shall be stored in a business offering retrieval services for 11 years after the closure date or according to Paragraph (b) of this Rule if the patient was a minor.
(d) The manager of medical records may authorize the digital archiving of medical records. Digital archiving may be done on or off the premises. If done off the premises, the facility shall provide for the confidentiality and safekeeping of the records. The original of digital archived medical records shall not be destroyed until the medical records department has had an opportunity to review the digital record for content.
(e) Nothing in this Section shall be construed to prohibit the use of automation in the medical records service, provided that all of the provisions in this Rule are met and the information is readily available for use in patient care.
(f) Only personnel authorized by State laws and the Health Insurance Portability and Accountability Act (HIPAA) found in 42 CFR 482, which is incorporated by reference including subsequent amendments and editions, shall have access to medical records. This regulation may be obtained free of charge at https://www.govinfo.gov/help/cfr. Where the written authorization of a patient is required for the release or disclosure of health information, the written authorization of the patient or authorized representative shall be maintained in the original record as authority for the release or disclosure.

(g) Medical records are the property of the hospital, and shall remain the property of the hospital, except through a court order. Copies shall be made available for authorized purposes such as insurance claims and physician review.

History Note: Authority G.S. 131E-97; 143B-165;
Eff. January 1, 1996;
Amended Eff. July 1, 2009;
Readopted Eff. August 1, 2023.

10A NCAC 13B .3904 PATIENT ACCESS

The manager of medical records shall provide patients or patient designees, when requested, access to or a copy of their medical records, or both. Upon the death of a patient, the executor of the decedent's estate, or in the absence of an executor, the next of kin responsible for the disposition of the remains, shall have access to all medical records of the deceased patient. The patient or the patient's next of kin may be charged for the cost of reproducing copies.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3905 PATIENT MEDICAL RECORDS

(a) Hospital management shall maintain medical records for each patient treated or examined in the facility.
(b) The medical record or medical record system shall provide data for each episode of care and treatment rendered by the facility.
(c) Where the medical record does not combine all episodes of inpatient, outpatient and emergency care, the medical records system shall:

(1) assemble, upon request of the physician, any or all divergently located components of the medical record when a patient is admitted to the facility or appears for outpatient or clinic services; or
(2) require placing copies of pertinent portions of each inpatient's medical record, such as the discharge resume, the operative note and the pathology report, in the outpatient or combined outpatient emergency unit record file as directed by the medical staff.

(d) The manager of medical records shall ensure that:

(1) each patient's medical record is complete, readily accessible and available to the professional staff concerned with the care and treatment of the patient;
(2) all clinical information pertaining to a patient is incorporated in his medical record;
(3) all entries in the record are dated and authenticated by the person making the entry;
(4) symbols and abbreviations are used only when they have been approved by the medical staff and when there exists a legend to explain them;
(5) verbal orders include the date and signature of the person recording them. They shall be given and authenticated in accordance with the provisions of Rule .3707(c) of this Subchapter; and
(6) records of patients discharged are completed within 30 days following discharge or disciplinary action is initiated as defined in the medical staff bylaws.

History Note: Authority G.S. 131E-75; 131E-79; 143B-165;
Eff. January 1, 1996;
Amended Eff, April 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3906 CONTENTS

(a) The medical record shall contain sufficient information to justify the diagnosis, verify the treatment and document the course of treatment and results accurately.
(b) All in-patient records shall include the following information:

(1) identification data (name, address, age, sex) and, when the identification data is not obtainable, the reason for such;
(2) date and time of admission and discharge;
(3) medical history:

(A) chief complaint;
(B) details of the present illness;
(C) relevant past, social, and family histories; and
(D) reports of relevant physical examinations;

(4) diagnostic and therapeutic orders;
(5) reports of procedures, tests and their results;
(6) provisional or admitting diagnosis;
(7) evidence of appropriate informed consent or a written statement explaining why consent was not obtained;
(8) clinical observations, including results of therapy;
(9) record of medication and treatment administration;
(10) progress notes of all disciplines;
(11) conclusions at termination of hospitalization or evaluation and treatment;
(12) all relevant diagnosis established by the time of discharge;
(13) consultation reports;
(14) surgical record, including anesthesia record, pre-operative diagnosis, surgeon's operative report and post-operative orders and any instructions given to the patient or family; and
(15) autopsy findings, if performed.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .3907 MEDICAL RECORDS REVIEW

The medical staff shall review medical records periodically for completeness and shall:

(1) establish requirements regarding completion of medical records, including a system for disciplinary actions for those who do not complete records in a timely manner; and
(2) make recommendations to the medical records department regarding clinical information sufficient for medical care evaluation.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

SECTION .4000 - OUTPATIENT SERVICES

10A NCAC 13B .4001 ORGANIZATION

(a) The facility shall establish and maintain outpatient care services in accordance with the facility's written mission statement.
(b) The relationship of outpatient services to other divisions within the facility, including channels of responsibility and authority, shall be documented and made available for review by the facility.
(c) The facility shall vest the direction of outpatient services in one or more individuals whose qualifications, authority and duties are defined in writing.
(d) The facility shall establish and maintain procedures for the review and evaluation of outpatient services.
(e) Each medical staff member shall have privileges delineated in accordance with criteria established by the medical staff by-laws, rules, or regulations.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4002 STAFFING

(a) The director of outpatient services shall require that ambulatory care services are staffed with sufficient personnel in accordance with a written plan.
(b) The responsibility for the delivery of outpatient services by the professional staff shall be defined and documented by the director of ambulatory care services.
(c) The facility shall provide education programs specifically related to outpatient care for the staff and document the extent of participation in education and training programs.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4003 POLICIES AND PROCEDURES
(a) The provision of outpatient services shall be guided by written policies and procedures which shall be developed by the facility and approved by the medical staff. The policies and procedures shall be reviewed by the medical staff at least every three years.
(b) The policies shall include the following:
(1) patient access to outpatient services;
(2) the process of obtaining informed consent;
(3) the location, storage and procurement of medications, supplies and equipment; and
(4) the mechanism to be used to contact patients for necessary follow-up.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4004 OUTPATIENT SURGICAL AND ANESTHESIA SERVICES
(a) When surgical or anesthesia services are provided in an outpatient setting, the facility shall require that the medical staff approve all types of surgical procedures to be offered. The facility shall maintain and make available a current listing of approved outpatient procedures.
(b) The facility shall define the scope of anesthesia services that may be provided, the locations where such anesthesia services may be administered and who shall provide anesthesia services.
(c) The facility shall require that standards for informed consent, history and physical examination, preoperative studies, administration of anesthesia, medical records and discharge criteria meet the same standards of care as apply for inpatient surgery unless otherwise specified by the medical staff.
(d) The facility shall provide for back-up service by other departments in the case of emergencies or complications.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4005 MEDICAL RECORDS
(a) The manager of outpatient services shall require that a record of outpatient care and services for each patient is maintained either in the ambulatory care services or medical records department.
(b) The facility shall develop a system of identification and filing to prepare for safe storage and prompt retrieval of records upon subsequent inpatient or outpatient visits.
(c) The facility shall establish medical records procedures which include provisions for maintaining the confidentiality of patient information and for the release of information to authorized individuals.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

SECTION .4100 - EMERGENCY SERVICES

10A NCAC 13B .4101 EMERGENCY RESPONSE CAPABILITY REQUIRED

The medical staff of each facility shall require that facility personnel are capable of initiating life-saving measures at a first-aid level of response for any patient or person in need of such services. This shall include:

(1) initiating basic cardio-respiratory resuscitation according to American Red Cross or American Heart Association standards;
(2) availability of first-line emergency drugs as specified by the medical staff;
(3) availability of IV fluids and supplies required to establish IV access; and
(4) establishing protocols or agreements for the transfer of patients to a facility for a higher level of care when these services are not available on site.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4102 CLASSIFICATION OF OPTIONAL EMERGENCY SERVICES

(a) Any facility providing emergency services shall classify its capability in providing such services according to the following criteria:

(1) Level I:
    (A) the facility shall have a comprehensive, 24-hour-per-day emergency service with at least one physician experienced in emergency care on duty in the emergency care area;
    (B) the facility shall have in-hospital physician coverage by members of the medical staff or by senior-level residents for at least medical, surgical, orthopedic, obstetric, gynecologic, pediatric and anesthesia services;
    (C) services of other medical and surgical specialists shall be available; and
    (D) the facility shall provide prompt access to labs, radiology, operating suites, critical care and obstetric units and other services as defined by the governing body.
(2) Level II:
    (A) the facility shall have 24-hour per day emergency service with at least one physician experienced in emergency care on duty in the emergency care area; and
    (B) the facility shall have consultation available within 30 minutes by members of the medical staff or by senior level residents to meet the needs of the patient. Consultation by phone is acceptable.
(3) Level III: The facility shall have emergency service available 24 hours per day with at least one physician available to the emergency care area within 30 minutes through a medical staff call roster.

(b) Facilities seeking trauma center designation shall comply with G.S. 131E-162.
(c) The location of the emergency access area shall be identified by clearly visible signs.

History Note: Authority G.S. 131E-79;
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4103 PROVISION OF EMERGENCY SERVICES

(a) Any facility providing emergency services shall establish and maintain policies requiring medical screening, treatment and transfer services for any individual who presents to the facility emergency department and on whose behalf treatment is requested regardless of that person's ability to pay for medical services and without delay to inquire about the individual's method of payment.
(b) Any facility providing emergency services under the rules of this Section shall install, operate, and maintain, on a 24-hour per day basis, an emergency two-way radio capable of accessing the North Carolina Voice Interoperability Plan for Emergency Responders (VIPER) radio network for voice communication with EMS providers transporting patients to the facility or provide on-line medical direction for EMS personnel.

(c) All communication equipment shall be in compliance with the rules set forth in 10A NCAC 13P, Emergency Medical Services and Trauma Rules.

History Note: Authority G.S. 143B-165;
Eff. January 1, 1996;
Readopted Eff. August 1, 2023.

10A NCAC 13B .4104 MEDICAL DIRECTOR

(a) The governing body shall establish the qualifications, duties, and authority of the director of emergency services. Appointments shall be recommended by the medical staff and approved by the governing body.
(b) The medical staff credentials committee shall approve the mechanism for emergency privileges for physicians employed for brief periods of time such as evenings, weekends, or holidays.
(c) Level I and II emergency services shall be directed and supervised by a physician.
(d) Level III services shall be directed and supervised by a physician.

History Note: Authority G.S. 131E-85(a); 143B-165;
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Readopted Eff. August 1, 2023.

10A NCAC 13B .4105 NURSING

(a) Level I and Level II emergency services shall have one or more registered nurses assigned and on duty within the emergency service area at all times.
(b) A Level III emergency service shall have a registered nurse available on at least an on-call, in-house basis at all times.
(c) The facility shall document that all emergency services nursing personnel shall have orientation, training and continuing education in the reception and care of emergency patients.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4106 POLICIES AND PROCEDURES

Each emergency department shall establish written policies and procedures that specify the scope and conduct of patient care to be provided in the emergency areas. They shall include the following:

(1) the location, storage, and procurement of medications, blood, supplies, equipment, and the procedures to be followed in the event of equipment failure;
(2) the initial management of patients with burns, hand injuries, head injuries, fractures, multiple injuries, poisoning, animal bites, gunshot or stab wounds, and other acute problems;
(3) the provision of care to an unemancipated minor not accompanied by a parent or guardian, or to an unaccompanied unconscious patient;
(4) management of alleged or suspected child, elder, or adult abuse;
(5) the management of pediatric emergencies;
(6) the initial management of patients with actual or suspected exposure to radiation;
(7) management of alleged or suspected rape victims;
(8) the reporting of individuals dead on arrival to the proper authorities;
(9) the use of standing orders;
(10) tetanus and rabies prevention or prophylaxis; and
(11) the dispensing of medications in accordance with State and federal laws.

History Note: Authority G.S. 143B-165;
Eff. January 1, 1996;
Readopted Eff. August 1, 2023.

10A NCAC 13B .4107 EMERGENCY RECORDS

(a) The facility shall require all levels of emergency departments to maintain a continuous control register on each patient seen for services which shall include at least the name, age, sex, date, time, and means of arrival, nature of complaint, disposition, and time of discharge.
(b) The facility shall maintain a record for each patient seeking emergency care. This shall include:
(1) patient identification, time and means of arrival;
(2) pertinent history and physical findings and patient vital signs;
(3) diagnostic and therapeutic orders;
(4) clinical observations including results of treatment;
(5) reports of procedures, tests and results;
(6) diagnostic impression; and
(7) discharge or transfer summary of treatment including final disposition, the patient's condition, and any instructions given to the patient and or family for follow-up care.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4108 OBSERVATION BEDS
When observation beds are used, the facility shall implement written policies and procedures that address the type of patient use, the mechanism for providing appropriate clinical monitoring, the length of time services may be provided in this setting and documentation requirements.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4109 TRANSFER
(a) The facility shall establish and implement protocols for stabilization and transportation of emergency patients.
(b) A facility with specialized capabilities, such as burn units, shock-trauma units and neonatal intensive care units, shall not refuse to accept an appropriate transfer for those services if the hospital has the capacity to treat the individual.
(c) The facility shall not transfer a patient until the receiving organization has consented to accept the patient and the patient is sufficiently stable for transport.
(d) If the patient or the person acting on the patient's behalf refuses transfer, the facility staff shall:
(1) explain to the individual or his representative the risks and benefits of transfer; and
(2) shall request the patient's or his representative's refusal of transfer in writing.
(e) The facility shall forward at the time of transfer a copy of all medical records related to the emergency condition for which the individual has presented.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4110 DISASTER AND MASS CASUALTY PROGRAM
(a) The facility shall describe:
(1) the level of emergency services available during an external disaster;
(2) the emergency department's role in the facility's external disaster plan;
(3) procedures to be followed in the event of an internal disaster; and
(4) the facility's connection to other community services such as fire, police and the American Red Cross.
(b) The medical staff and governing body shall approve the plan, review it and revise it if needed, annually.
(c) The plan shall:
(1) provide for prompt medical attention for all emergency patients as their needs may dictate;

(2) include protocols for handling non-emergency cases;
(3) establish medical staff coverage procedures or methods;
(4) specify drugs, solutions and equipment to be continuously available;
(5) provide for the evacuation and transfer for all inpatients as their needs may indicate in the event of an internal disaster; and
(6) include mutual support agreements with area providers.

(d) Schedules, names and telephone numbers of all physicians and others on emergency duty shall be maintained by the facility.
(e) Names and telephone numbers of those to be contacted in the event of an internal disaster shall be maintained by the facility.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

SECTION .4200 - SPECIAL CARE UNITS

10A NCAC 13B .4201 ORGANIZATION

(a) The governing body shall approve the type and scope of special care units.
(b) The facility shall document the relationship of the special care units to the other departments within the hospital, including channels of responsibility and authority.
(c) The facility shall provide necessary equipment and supplies for delivery of nursing care specific to the unit population for each special care unit.
(d) The facility shall provide sufficient emergency drugs and equipment to meet anticipated needs as determined by the medical staff.
(e) The governing body shall delegate to the medical and nursing staff the responsibility to develop policies and procedures concerning the scope and provision of safe care in each unit.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4202 MEDICAL STAFF

(a) The governing body shall provide that each special care unit or group of similar units be directed by qualified members of the medical staff whose clinical and administrative privileges have been approved by the governing board.
(b) The governing body shall designate the director to be responsible for making decisions in consultation with the physician responsible for the patient, for the disposition of a patient when patient load exceeds optimal operation capacity.
(c) The governing body shall require that the medical staff provide medical staff coverage sufficient to meet the specific needs of the patients on a 24-hour basis.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4203 NURSING STAFF

The supervision of nursing care for each special care unit shall be provided by a qualified registered nurse and shall include the following:

(1) unit-specific orientation and competency evaluation for each staff member;
(2) a staffing plan based upon the needs of the patient population which is implemented to ensure a sufficient number of qualified Registered Nurses are on duty when patients are in the unit;

(3) assessment, planning, implementation and evaluation of nursing care which is documented according to policy; and
(4) delivery of nursing care in accordance with the North Carolina Nurse Practice Act.

History Note: Authority G.S. 131E-79;
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4204 POLICIES AND PROCEDURES

(a) The facility in conjunction with the medical and nursing staff shall develop written policies and procedures which guide the provision of care in a special care unit. These policies and procedures shall be approved by the medical staff and include:
(1) patient admission and discharge criteria;
(2) notification of appropriate medical staff for changes in the condition of the patient;
(3) use of standing orders and emergency protocols;
(4) designation of staff members authorized to perform special procedures and special circumstances requiring such authorization;
(5) patient care procedures, including medication administration;
(6) infection control;
(7) pertinent safety practices;
(8) use of equipment and procedures to be followed in the event of equipment failure;
(9) regulations governing visitors and traffic control; and
(10) role of special care unit in internal and external disaster plans.

(b) The governing body shall review, update and approve regularly, but at least every three years, its policies and procedures.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

SECTION .4300 - MATERNAL - NEONATAL SERVICES

10A NCAC 13B .4301 ORGANIZATION MATERNAL SERVICES

(a) The governing body shall approve the scope of obstetric services offered based upon the level of patient need, qualifications of the credentialed staff, and resources of the facility.

(b) The following capabilities and minimum services shall be made available when obstetric services are provided:
(1) identification of high-risk mothers and fetuses;
(2) continuous electronic fetal monitoring;
(3) cesarean delivery capability within 30 minutes of decision;
(4) blood or fresh frozen plasma for transfusion;
(5) anesthesia on a 24-hour or on-call basis;
(6) radiology and ultrasound examination;
(7) stabilization of unexpectedly small or sick neonates before transfer;
(8) neonatal resuscitation;
(9) laboratory services on a 24-hour or on-call basis;
(10) consultation and transfer agreements;
(11) assessment and care for the neonates; and
(12) nursery or other appropriate space for care of the neonates.

(c) In a facility without intensive care nursery services, the facility management shall establish and maintain a plan for the stabilization and transportation of sick newborns to a regional neonatal unit.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4302 MEDICAL STAFF MATERNAL SERVICES

(a) The medical staff shall require that each birth be attended by a physician or certified nurse midwife who has documented evidence of current competence and appropriate privileges.

(b) At all times medical staff with obstetrical privileges shall be available within 30 minutes to provide services and attend deliveries. An on-call schedule shall be available to the Division for review.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4303 NURSING SERVICES MATERNAL SERVICES

(a) The nurse executive or the decentralized nursing management staff shall designate a registered nurse who has education, training, and experience in obstetrical care as supervisor of obstetrical services.

(b) A registered nurse shall be responsible for providing the type and amount of nursing care needed by each patient. A staffing plan shall be available to the Division for review.

History Note: Authority G.S. 131E-79;
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4304 POLICIES AND PROCEDURES MATERNAL SERVICES

(a) The provision of patient care shall be guided by written policies and procedures developed by the medical and nursing staff and approved by the medical staff.

(b) Written policies shall relate to at least the following:

- (1) a system for informing the physician or certified nurse midwife responsible for a patient of the following:
  - (A) the patient's admission;
  - (B) the onset of labor; and
  - (C) pertinent information about progress of labor or changes in patient's condition.
- (2) emergency response protocols for patients who demonstrate evidence of maternal, fetal or neonatal distress;
- (3) a program to prevent isoimmunization of RH-negative mothers;
- (4) administration of oxytocic agents when used for induction or stimulation of labor;
- (5) the use and administration of analgesics and anesthetics;
- (6) administration of magnesium sulfate when and for the treatment preeclampsia;
- (7) the location and storage of medications, supplies, and special equipment;
- (8) the method of identification for the neonates;
- (9) assessment and care of the neonates;
- (10) provision of resuscitation, stabilization, and preparation for the transport of sick neonates at any hour; and
- (11) an infection control plan.

(c) Accurate and complete medical records shall be provided for each obstetric patient.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4305 ORGANIZATION OF NEONATAL SERVICES

(a) The governing body shall approve the scope of all neonatal services and the facility shall classify its capability in providing a range of neonatal services using the following criteria:

(1) LEVEL I: Full-term and pre-term neonates that are stable without complications. This may include infants who are small for gestational age or neonates who are large for gestational age.

(2) LEVEL II: Neonates or infants that are stable without complications but require special care and frequent feedings; infants of any weight who no longer require LEVEL III or LEVEL IV neonatal services, but who still require more nursing hours than normal infant. This may include infants who require close observation in a licensed acute care bed.

(3) LEVEL III: Neonates or infants that are high-risk, small or approximately 32 and less than 36 completed weeks of gestational age but otherwise healthy, or sick with a moderate degree of illness that are admitted from within the hospital or transferred from another facility requiring intermediate care services for sick infants, but not requiring intensive care. The beds in this level may serve as a "step-down" unit from Level IV. Level III neonates or infants require less constant nursing care, but care does not exclude respiratory support.

(4) LEVEL IV (Neonatal Intensive Care Services): High-risk, medically unstable, or critically ill neonates under 32 weeks of gestational age, or infants, requiring constant nursing care or supervision that includes continuous cardiopulmonary or respiratory support, complicated surgical procedures, or other intensive supportive interventions.

(b) The facility shall provide for the availability of equipment, supplies, and clinical support services.

(c) The medical and nursing staff shall develop and approve policies and procedures for the provision of all neonatal services.

History Note: Authority G.S. 143B-165;
Eff. January 1, 1996;
Temporary Amendment Eff. March 15, 2002;
Amended Eff. April 1, 2003;
Readopted Eff. August 1, 2023.

10A NCAC 13B .4306 MEDICAL STAFF OF NEONATAL SERVICES

The medical staff shall require that the director or other designated physician in charge of the neonatal special or intensive care unit has training and experience in care of the neonate.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4307 NURSING STAFF OF NEONATAL SERVICES

(a) The nurse executive or the decentralized nursing management staff shall designate a registered nurse who has training and experience in the care of neonates as supervisor of neonatal services.

(b) A registered nurse shall be responsible for providing the type and amount of nursing care needed by each patient. A staffing plan shall be available to the Division for review.

(c) The nursing staff shall provide educational opportunities for parents of neonates on routine care and procedures needed by the neonate.

(d) The nursing staff shall provide opportunities for parental participation in care of the neonate to facilitate bonding and family adjustment to the neonate's needs.

History Note: Authority G.S. 131E-79;
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4308 POLICIES AND PROCEDURES OF NEONATAL SERVICES

(a) The provision of neonatal care at all levels shall be guided by written policies and procedures developed and approved by the medical and nursing staffs.

(b) The policies and procedures shall include but are not limited to:

(1) emergency resuscitation and stabilization of the neonate;
(2) equipment for routine and emergency care of the neonate;
(3) continuous oxygen supply and means of administration including ventilators;
(4) administration of medications;
(5) insertion and care of invasive lines;
(6) prevention of infectious diseases or processes; and
(7) family involvement in care of the neonate.

(c) The medical and nursing staff shall review, update and approve its policies and procedures every three years.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

SECTION .4400 - RESPIRATORY CARE SERVICES

10A NCAC 13B .4401 ORGANIZATION

(a) The governing body shall appoint a medical director of the respiratory care service who is an anesthesiologist, pulmonologist or other qualified physician.
(b) The facility shall appoint a qualified individual as the director of respiratory care services.
(c) When the facility is without a distinct respiratory care service, the facility shall:

(1) designate the department responsible for the delivery of respiratory care services;
(2) designate a person to supervise the delivery of respiratory care services; and
(3) establish and maintain policies and procedures for the delivery of respiratory care services offered.

History Note: Authority G.S. 131E-79;
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4402 STAFFING

(a) Staffing numbers shall be determined by the types and complexities of the services offered.
(b) The director of the service shall provide for the availability of trained respiratory technicians, Certified Respiratory Therapy Technicians, registry eligible or Registered Respiratory Therapist needed for the scope of services offered.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4403 POLICIES AND PROCEDURES

The facility shall establish and maintain written policies and procedures for the services offered. These shall include but are not limited to:

(1) scope of services and treatment offered;
(2) medication administration;
(3) cleaning, assembly and storage of equipment;
(4) safety;
(5) infection control;
(6) documentation of delivered care or treatments; and
(7) care and supervision of all ventilated patients.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

SECTION .4500 - PHARMACY SERVICES AND MEDICATION ADMINISTRATION

10A NCAC 13B .4501 PROVISION OF SERVICE

The facility shall provide for pharmaceutical services which are administered in accordance with the pharmacy laws of North Carolina including but not limited to G.S. 90 and G.S. 106.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4502 PHARMACIST

(a) The pharmacy service shall be directed by a pharmacist licensed by the State of North Carolina. If a facility has a limited service as defined by the N.C. Board of Pharmacy, a part-time director of pharmacy shall have responsibility for control and dispensing of drugs.
(b) The director of pharmacy shall be responsible to the chief executive officer or his designee for developing, supervising, and coordinating all the activities of pharmacy services throughout the facility.
(c) The director of pharmacy shall require that the pharmacists are trained in the specialized functions of facility pharmacy.
(d) The dispensing of drugs in the absence of a pharmacist shall be done by facility staff under the direct supervision of staff approved by the pharmacy committee and who are responsible for following policies established by the pharmacy committee.

History Note: Authority G.S. 131E-79;
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4503 STAFF

The director of pharmacy shall be assisted by additional pharmacists and such other personnel as the activities of the pharmacy may require to meet the pharmaceutical needs of the patients served.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4504 PHARMACY COMMITTEE

(a) A pharmacy committee or its equivalent, to include physicians, registered nurses, pharmacists and the administrator or designee shall be established.
(b) The committee shall meet at least quarterly, record its proceedings and report to the medical staff. It shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use and safety procedures, and all other matters relating to drugs in the facility. This shall include a mechanism to review and evaluate adverse drug reactions and drug usage evaluations, offering appropriate recommendations, actions, and follow-up if necessary. The committee shall:

(1) serve as an advisory group to the medical staff and the pharmacy director on matters pertaining to drug selection;
(2) develop an ongoing mechanism to review a formulary or drug list for use in the hospital;
(3) recommend and develop policies regarding the use and control of investigational drugs and research in the use of U.S. Food and Drug Administration approved drugs;
(4) evaluate clinical data concerning new drugs or preparations requested for use in the facility;
(5) make recommendations concerning drugs to be stocked on the nursing units and by other services;

(6) establish mechanisms which will prevent formulary duplication;
(7) establish policies and procedures that address therapeutic drug substitution;
(8) establish a policy describing the duration of drug therapy or number of doses for all medication orders; and
(9) make recommendations regarding medication administration policies and procedures.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4505 PHARMACY FACILITIES
(a) The facility shall provide sufficient space for the pharmaceutical service to carry out its professional and administrative functions.
(b) Equipment shall be provided for the storage, preparation, dispensing, distributing and safeguarding of drugs throughout the hospital.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4506 SUPPLIES
The director of pharmacy shall maintain an inventory of drugs and pharmaceutical devices to meet the needs of the patients as described in the facility's formulary.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4507 STORAGE
(a) All drugs and related pharmaceutical supplies located throughout the facility shall be under the control of the pharmacy service.
(b) All areas where drugs and related pharmaceutical supplies are stored shall be monitored at least monthly by the pharmacy service.
(c) The director of pharmacy shall require that corresponding records are maintained of drug inventory variances and the corrective action taken.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4508 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .4509 SECURITY
(a) The director of pharmacy shall require that all drugs and related pharmaceutical supplies be stored in a lockable environment except when under the direct supervision of personnel authorized by the pharmacy committee to handle drugs.
(b) Controlled substances and other drugs the facility deems subject to abuse shall be stored as outlined in the U.S. Controlled Substance Act, 21 CFR 1301.41 and the N.C. Controlled Substances Act, G.S. 90, Article 5. These rules are available from the N.C. Drug Control Unit of the N.C. Division of Mental health, Development Disabilities & Substance Abuse Services, 3008 Mail Service Center, Raleigh, NC 27699-3008 (919-733-1765) without charge to current registrants.

(c) All keys and other locking devices to the pharmacy and controlled substances throughout the facility shall be under the control of the director of pharmacy and the facility management.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017;
Amended Eff. October 1, 2019.

10A NCAC 13B .4510 RECORDS

(a) The director of pharmacy shall provide that all drug transactions of the pharmacy shall be recorded as described in policies approved by the pharmacy committee.
(b) The director of pharmacy shall establish and maintain a system of records and bookkeeping in accordance with the policies of the facility in order to maintain adequate control over the requisitioning and dispensing of all drugs and pharmaceutical supplies and over patient billing for all drugs and pharmaceutical supplies.
(c) The director of pharmacy shall maintain records for all drugs purchased, ordered, dispensed, distributed, returned and disposed of in accordance with the pharmacy laws of North Carolina from the pharmacy.
(d) Verbal orders for drugs shall be subject to medical staff policies.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4511 MEDICATION ADMINISTRATION

(a) A facility shall establish and maintain policies and procedures governing the administration of medications which shall be enforced and implemented by administration and staff. Policies and procedures shall include:
(1) accountability of controlled substances as defined by the G.S. 90, Article 5; and
(2) storage, distribution, administration and monitoring the effects of medications.
(b) All medications and treatments shall be administered and discontinued in accordance with signed medical staff orders which are recorded in the patient's medical record.
(c) The categories of staff that are privileged to administer medications shall be delineated by the operational policies of the facility. These policies shall be in agreement with current rules of North Carolina Occupational Boards for each category of staff.
(d) Medications shall be scheduled and administered according to the established policies of the facility.
(e) Variances to the medication administration policy shall be reviewed and evaluated by the nurse executive or her designee.
(f) The person administering medications shall identify each patient in accordance with the facility's policies and procedures prior to administering any medication.
(g) Medication administered to a patient shall be recorded in the patient's medication administration record immediately after administration in accordance with the facility's policies and procedures.
(h) Omission of medication and the reason for the omission shall be indicated in the patient's medical record.
(i) The person administering medications which are ordered to be given as needed (PRN) shall justify the need for the same in the patient's medical record.
(j) Medication administration records shall provide identification of the drug and strength of drug, quantity of drug administered, route administered, name and title of person administering the medication, and time and date of administration.
(k) Self-administration of medications shall be permitted only if prescribed by the medical staff. Directions must be printed on the container.
(l) The administration of one patient's medications to another patient is prohibited except in the case of an emergency. In the event of such as emergency, steps shall be taken by a pharmacist to ensure that the borrowed medications shall be replaced and so documented.
(m) Verbal orders shall be signed in accordance with Rule .3707(c) of this Subchapter.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;

Amended Eff. November 1, 2005; May 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4512 MEDICATIONS DISPENSED

(a) Except as provided in Paragraph (c) of this Rule, the pharmacy shall dispense only those drugs which are listed in one or more of the references listed in Paragraph (b) of this Rule. No drug which is listed in Paragraph (b) of this Rule shall be used for any purpose which is not approved by the U.S. Food and Drug Administration unless the use has been approved by the facility's pharmacy committee.
(b) References:
- (1) United States Pharmacopoeia;
- (2) National Drug Formulary;
- (3) Evaluations of Drug Interactions by the American Pharmaceutical Association;
- (4) American Hospital Formulary Service; and
- (5) Other references approved by the Pharmacy Committee.

(c) Any drug approved for use as an investigational drug or otherwise by the U.S. Food and Drug Administration but not listed in Paragraph (b) of this Rule may be used in accordance with standards established by the facility's pharmacy committee, or its equivalent and approved by the U.S. Food and Drug Administration, Dockets Management Branch, Room 1061, 5630 Fishers Lane, Rockfield, Maryland 20852, at a cost dependent on the material requested.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017;
Amended Eff. October 1, 2019.

10A NCAC 13B .4513 DRUG DISTRIBUTION SYSTEMS

(a) The pharmacy committee shall develop written policies and procedures pertaining to the intra-facility drug distribution system. In developing such policies the committee shall utilize representatives of other disciplines within the facility, including nursing services.
(b) The label of each patient's individual medication container shall bear all information required by the Pharmacy Laws of North Carolina.
(c) The pharmacist, with the advice and guidance of the pharmacy committee or its equivalent, shall be responsible for specifications as to quality, quantity and source of supplies of all drugs.
(d) There shall be a formulary or list of drugs accepted for use in the facility which shall be developed and amended as necessary by the pharmacy committee.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4514 EMERGENCY PHARMACEUTICAL SERVICES

The director of pharmacy shall be responsible for emergency pharmaceutical services as currently described in the Pharmacy Laws of North Carolina.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4515 DISPOSITION

Drugs, and pharmaceutical devices which are outdated, visibly deteriorated, unlabeled, inadequately labeled, recalled, discontinued or obsolete shall be identified by a pharmacist and shall be disposed of in compliance with applicable state and federal laws and regulations.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4516 COMMERCIAL PHARMACEUTICAL SERVICE

A facility using an outside pharmacist or pharmaceutical service must have a contract with that pharmacist or service. As part of the contract, the pharmacist or service shall be required to maintain at least the standards for operation of the pharmaceutical services outlined in this Subchapter.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

SECTION .4600 - SURGICAL AND ANESTHESIA SERVICES

10A NCAC 13B .4601 ORGANIZATION

(a) The governing body shall approve the types of surgery and types of anesthesia services to be available throughout the hospital consistent with identified needs and resources.
(b) The facility shall require that surgical or anesthesia procedures are performed only when the necessary equipment and personnel are available.
(c) A facility that provides surgical or obstetric services shall provide anesthesia services on a 24-hour basis.
(d) The requirements and standards identified in this Section apply when any patient, in any setting, receives for any purpose, by any route:

(1) general, spinal or other major regional anesthesia; or
(2) sedation or analgesia that may result in the loss of protective reflexes; or
(3) surgery or other invasive procedure while receiving such anesthesia.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4602 DIRECTOR OF SURGICAL SERVICES

(a) Each department or service providing surgical services shall be directed by members of the medical staff whose clinical and administrative privileges have been approved by the governing body.
(b) The medical staff shall establish and maintain a system for monitoring and evaluating the quality and appropriateness of the care and treatment of surgical patients, and for monitoring the clinical performance of all individuals with clinical privileges.
(c) In facilities where there is no anesthesiologist on staff the facility shall:

(1) with review of the medical staff, establish a consultation agreement with a board-certified or board-eligible anesthesiologist for the purpose of establishing policies and procedures that relate to the safe administration of anesthesia in all departments or services of the facility;
(2) assume the responsibility for establishing general policies for anesthesia services; and
(3) establish a line of communication and supervision for staff.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4603 SURGICAL AND ANESTHESIA STAFF

The facility shall develop processes that require each individual provide only those services for which proof of licensure and competency can be demonstrated. The facility shall require that:

(1) when anesthesia is administered, a physician is available in the facility to provide care in the event of a medical emergency;
(2) a roster of practitioners with a delineation of current surgical and anesthesia privileges is available and maintained for the service;
(3) an on-call schedule of surgeons with privileges to be available at all times for emergency surgery and for post-operative clinical management is maintained;
(4) the operating room is supervised by a registered nurse or doctor of medicine or osteopathy; and
(5) an operating room register which shall include date of the operation, name and patient identification number, names of surgeons and surgical assistants, name of anesthetists, type of anesthesia given, pre- and post-operative diagnosis, type and duration of surgical procedure, and the presence or absence of complications in surgery is maintained.

History Note: Authority G.S. 131E-85; 143B-165;
Eff. January 1, 1996;
Readopted Eff. August 1, 2023.

10A NCAC 13B .4604 DIRECTION OF ANESTHESIA SERVICES

(a) The facility shall be organized, directed and integrated with other related services or departments of the facility.
(b) The department of anesthesia shall require that all anesthetics are administered according to procedures established in medical staff rules. In facilities where there is no department of anesthesia, the medical staff shall assume the responsibility for establishing general policies and for supervising the administration of anesthetics.
(c) The facility shall provide that anesthesia services be directed by a member, or members, of the medical staff whose responsibilities shall be approved by the governing body and shall include:
(1) establishment of criteria and procedures for the evaluation of the quality of all anesthesia care rendered;
(2) review of clinical privileges for all licensed practitioners whose primary clinical activity is the provision of anesthesia services; and
(3) establishment of written policies and procedures for anesthesia services.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4605 POLICIES AND PROCEDURES

(a) The director of surgical services shall develop policies and procedures for surgical and anesthesia services which shall be available to the medical, surgical, anesthesia staff and nursing personnel.
(b) The facility shall require that policies on anesthesia procedures include the delineation of pre-anesthesia and post-anesthesia responsibilities.
(c) The facility shall require that the policies listed in this Paragraph are followed and that each surgical patient's record contain the following documentation:
(1) a complete history and physical documented in the record of every patient prior to surgery, including clinical indications for the surgical procedure;
(2) written evidence of informed consent, in the patient's record before surgery. If prior written consent was not obtained, the record shall contain a written explanation of why prior consent was not obtained;
(3) an evaluation of the patient and anesthesia planned, documented according to medical staff bylaws by an individual qualified to administer anesthesia services. Re-evaluation of the patient immediately prior to the induction of anesthesia shall be performed prior to surgery;
(4) an operative report describing techniques, findings, tissue removed or altered, and pre and post-surgical diagnosis. This report must be written or dictated following surgery and signed by the surgeon in compliance with medical staff rules;
(5) an intraoperative anesthesia record including the dosage of all drugs and agents used, the duration of anesthesia, and the type and amount of all fluids or blood and blood products administered shall be documented;

(6) evaluation and documentation of the postoperative status of the patient on admission to and discharge from the post-anesthesia recovery area.

(d) The director of anesthesia services shall establish criteria for discharge and facility management shall require that a physician or CRNA with appropriate clinical privileges be responsible for the decision to discharge a patient from a post-anesthesia recovery area.

(e) The facility shall establish regulations governing visitors and traffic control.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

SECTION .4700 - NUTRITION AND DIETETIC SERVICES

10A NCAC 13B .4701 PROVISION OF SERVICES

The nutrition and dietetic services shall be organized, directed, staffed and integrated with other facility departments to provide optimal nutritional therapy and quality food service to patients. Nutrition therapy shall apply the principles of the science of nutrition and be administered in accordance with the law and rules including but not limited to G.S. 90, Article 25.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4702 ORGANIZATION

(a) The nutrition and dietetic services shall be under the full-time direction of a person who is trained or experienced in food services administration and therapeutic diets. The director shall be one of the following:

(1) A qualified dietitian;
(2) Bachelor's degree in Foods and Nutrition or Food Service Management;
(3) Dietetic Technician Registered (DTR); or
(4) Certified Dietary Manager (CDM); or
(5) An individual who is enrolled in a program to complete the minimum qualifications in Paragraph (a)(1)(2)(A)(B)(C) of this Rule.

(b) The nutrition and dietetic services of the facility shall have at least one dietitian either full-time, part-time, or as consultant. The qualifications of the dietitian shall be included in the personnel files. If the director of nutrition and dietetic services is not a registered dietitian, there shall be an established method of communication between the director and the dietitian which ensures that the dietitian supervises the nutritional aspects of patient care and ensures that quality nutritional care is provided to patients. Dietitians or qualified designees shall attend and participate in meetings relevant to patient nutritional care, including but not limited to patient care conferences and discharge planning.

(c) When a dietitian serves only in a consultant capacity, the facility management shall establish and maintain a written contract with the individual defining the responsibilities of the dietician including requirements for submission of written reports to the hospital administrator and the director of the nutrition and dietetic services describing the extent and quality of the services provided. Frequency of visits of the consultant dietitian shall be defined in the contract. The consultant dietitian shall provide, on site, no less than eight hours of service every two weeks to provide the nutritional aspects of patient care including but not limited to the following:

(1) approval of regular and modified menus, including standardized recipes;
(2) performance of nutritional assessments;
(3) development of nutrition care plans;
(4) provision of nutrition therapy;
(5) participation in development of policies and procedures; and
(6) monitoring and evaluation of the effectiveness and appropriateness of nutrition and dietetic services.

(d) The facility shall establish and maintain written policies and procedures to govern all nutrition and dietetic service activities. These policies shall be developed by the nutrition and dietetic services in cooperation with

personnel from other departments or services which are involved with nutrition and dietetic services and they shall be reviewed at least every three years, revised as necessary, and dated to indicate the time of last review. Administrative policies and procedures concerning food procurement, preparation, and service shall be written by the director of the nutrition and dietetic services. Nutritional care policies and procedures shall be written by the qualified dietitian. The nutrition and dietetic service policies and procedures shall include, but not be limited to the following:

(1) provision of food and nutrition therapy prescriptions/orders;
(2) development, approval and provision of regular and modified menus, including standardized recipes;
(3) food purchasing, storage, inventory, preparation and service;
(4) identification system designed to ensure that each patient receives appropriate diet as ordered;
(5) ancillary dietetic services, as appropriate, including food storage and kitchens on patient care units, formula supply, cafeterias, vending operations and ice making;
(6) preparation, storage, distribution, and administration of enteral nutrition programs;
(7) assessment and monitoring of patients receiving enteral and total parenteral nutrition;
(8) personal hygiene and health of dietetic personnel;
(9) infection control measures to minimize the possibility of contamination and transfer of infection, including establishment of monitoring procedure to ensure that personnel are free from communicable infections and open skin lesions; and
(10) pertinent safety practices, including control of electrical, flammable, mechanical, and radiation hazards.

(e) Nutrition and dietetic services shall be provided by qualified personnel under supervision to meet needs of patients. The director of the nutrition and dietetic services shall require that personnel assigned to the department perform all functions necessary to meet the nutritional needs of patients. The director or qualified designee shall attend and participate in meetings, including that of department heads, and function as an integral member of the facility.
(f) A facility which has a contract with an outside food management service, shall require as a part of the contract that the company complies with all applicable requirements and standards outlined in Section .4700 of this Subchapter for such service. The contract shall be available for review by the Division.

History Note: Authority G.S. 131E-79;
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4703 SANITATION AND SAFETY

(a) The nutrition and dietetic service shall comply with current laws and rules for sanitation as promulgated by the Commission for Public Health, including but not limited to 15A NCAC 18A .1300. Copies of 15A NCAC 18A .1300 may be obtained at no charge from the Environmental Health Section, Division of Public Health, N.C. Department of Health and Human Services, 1632 Mail Service Center, Raleigh, NC 27699-1632. The facilities and equipment of the nutrition and dietetic services shall also comply with applicable and safety laws and rules.
(b) Sufficient space and equipment shall be provided for the nutrition and dietetic services to accomplish the following:

(1) store food and nonfood supplies under sanitary and secure conditions;
(2) store food separately from nonfood supplies. When storage facilities are limited, paper products may be stored with food supplies;
(3) prepare and distribute food, including therapeutic diets;
(4) clean and sanitize utensils and dishes apart from food preparation areas; and
(5) allow personnel to perform their duties.

(c) Cleaning schedules and instructions for cleaning all equipment and work and storage areas shall be posted and followed in the nutrition and dietetic services area and accessible to all nutrition and dietetics staff. Procedures for cleaning all equipment and work areas shall be followed consistently and documented to safeguard the health of the patient.

History Note: Authority G.S. 131E-79;

Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017;
Amended Eff. October 1, 2019.

10A NCAC 13B .4704 DISTRIBUTION OF FOOD

(a) Food shall be transported and displayed pursuant to the rules adopted by the Commission for Public Health.
(b) At the time of serving, the temperature of hot foods shall be no less than:

(1) Hot liquids - 150 degrees Fahrenheit (minimum);
(2) Hot Cereal - 150 degrees Fahrenheit (minimum);
(3) Hot Soups - 130 degrees Fahrenheit (minimum); and
(4) Other hot foods - 110 degrees Fahrenheit (minimum).

(c) At the time of serving, the temperature of cold foods shall be no more than:

(1) Cold liquids - 50 degrees Fahrenheit (maximum); and
(2) Other cold foods - 65 degrees Fahrenheit (maximum).

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4705 NUTRITIONAL SUPPORT

(a) The administration of the nutritional support shall be directed by a qualified dietitian. Observations and information pertinent to nutrition therapy shall be documented in the medical record of the patient.
(b) The facility shall have a current nutrition care manual accessible to hospital personnel. The nutrition care manual shall be reviewed every three years, revised as necessary by a qualified dietitian, and approved jointly by the nutrition service and medical staff.
(c) Therapeutic diets and enteral and parenteral nutrition therapy shall be prescribed in written orders on the medical records and provided as ordered.
(d) The nutrition care manual shall reflect the standards for nutrition care in accordance with those referenced in the most current edition of "Recommended Dietary Allowance" of the Food and Nutrition Board of the National Research Council of the National Academy of Sciences which are hereby incorporated by reference. These standards include any subsequent amendments and editions of the referenced material and are available from the National Academy Press, 2101 Constitution Avenue, N.W., Lockbox 285, Washington, D.C. 20055 at a cost of six dollars ($6.00) per copy. The nutrition deficiencies of any modified diet that is not in compliance with the recommended dietary allowances shall be specified in the nutrition care manual.
(e) The qualified dietitian shall be responsible for the development of a nutritional care plan in compliance with medical staff's orders to meet the nutritional needs of the patient. The nutrition care plan shall be included in the medical record of the patient on his discharge plan and transfer orders to the extent necessary for continuity of care. Facilities with long term care units shall have at least a three week menu cycle in the long term care units.

History Note: Authority G.S. 131E-79;
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

SECTION .4800 - DIAGNOSTIC IMAGING

10A NCAC 13B .4801 ORGANIZATION

(a) Imaging services shall be under the supervision of a full-time radiologist, consulting radiologist, or a physician.
(b) Radio-therapy is a type of imaging service.
(c) All imaging equipment shall be operated under professional supervision by personnel trained in the use of imaging equipment and knowledgeable of all applicable safety precautions required by the North Carolina Department of Health and Human Services, Division of Health Service Regulation, Radiation Protection Section set forth in 10A NCAC 15, hereby incorporated by reference including subsequent amendments.

History Note: Authority G.S. 143B-165;
RRC objection due to lack of statutory authority and ambiguity Eff. July 13, 1995;
Eff. January 1, 1996;
Readopted Eff. August 1, 2023.

10A NCAC 13B .4802 RECORDS

(a) A documented record on each imaging examination shall be included in the patient's medical record.
(b) Imaging reports shall be signed by the physician interpreting the study.
(c) Copies of current reports made by private physicists or governing authority surveying the radiographic facilities shall be available to the Division.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4803 STAFFING

(a) The staffing of the imaging department shall be determined by the radiologist in charge or by another person designated by hospital management.
(b) There shall be a minimum of one radiologic technologist available to the department on at least an on-call basis.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4804 MONITORING RADIATION EXPOSURE OF PERSONNEL

(a) The facility shall establish procedures for the monitoring of personnel and shall maintain a record for each individual working in the area of radiation where there is a reasonable probability of receiving one-fourth of the maximum permissible dose.
(b) Records documenting the monitoring of personnel receiving radiation exposure through the use of film badges or dosimeters must also be maintained by the facility. Readings from badges or dosimeters shall be recorded on at least a monthly basis.
(c) Upon termination of employment, each employee shall be provided with a summary of his exposure record.
(d) Permanent records of radiological exposure on all monitored personnel shall be maintained for review by the Division.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4805 SAFETY

(a) The facility shall require that all imaging equipment is operated under the supervision of a physician and by qualified personnel.
(b) The facility shall require that caution is exercised to protect all persons from exposure to radiation.
(c) The governing authority shall appoint a radiation safety committee.
(d) All radio-active isotopes, whether for diagnostic, therapeutic, or research purposes shall be received, handled, and disposed of in accordance with the requirements of the North Carolina Department of Health and Human Services, Division of Health Service Regulation, Radiation Protection Section set forth in 10A NCAC 15, hereby incorporated by reference including subsequent amendments.

History Note: Authority G.S. 143B-165;
Eff. January 1, 1996;
Readopted Eff. August 1, 2023.

10A NCAC 13B .4806 NUCLEAR MEDICINE SERVICES
When nuclear medicine services are offered, the facility shall establish and maintain written policies and procedures for the provision of those services which shall provide for the safety of patients and staff, management of radioactive isotopes and the maintenance of equipment according to the manufacturers' recommendations.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

SECTION .4900 - LABORATORY SERVICES AND PATHOLOGY

10A NCAC 13B .4901 ORGANIZATION
The laboratory shall be under the supervision of a clinical pathologist, or a physician who has training in clinical laboratory diagnosis designated by the governing body.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4902 RECORDS
(a) All requests for laboratory services shall be documented.
(b) All reports of laboratory services performed, including autopsy, shall be placed in the patient's medical record.
(c) Records of proficiency testing appropriate to the scope of services offered shall be available to the Division for review.
(d) Records of equipment calibration and quality controls as recommended by the manufacturer shall be maintained and be available to the Division for review.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4903 STAFFING
The laboratory supervisor or his appointed designee, shall require that:
(1) procedures and tests conducted are within the scope of the laboratory as approved by the hospital;
(2) at least one qualified medical technologist is available at all times; and
(3) qualified staff are available to carry out the functions of the laboratory.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4904 TESTS
(a) Laboratory tests to be performed on a patient at the time of admission (if any) shall be established by the medical staff and be approved by the governing board of the hospital. In the event the medical staff and governing body elect not to establish routine laboratory tests for new admissions, the request for such tests shall be left to the discretion of the attending medical staff members.
(b) Serological tests for patients admitted shall be optional with the hospital. However, there shall be records indicating that obstetrical patients have had a serological test during their current pregnancy.
(c) When laboratories outside of the facility are used, such laboratories shall be approved by the governing body and medical staff of the facility. In case of such usage, a legible copy of the laboratory report must be included in the patient record.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4905 TISSUE REMOVAL AND DISPOSAL

(a) The medical staff shall establish and maintain written policies for pathological examination of tissue and specimens removed during surgery.
(b) Pathological waste disposal shall comply with the rules Governing the Sanitation of Hospitals, Nursing and Rest Homes, Sanitariums, Sanatoriums, and Educational and Other Institutions, contained in 15A NCAC 18A .1300. Copies of 15A NCAC 18A .1300 may be obtained at no charge from the Environmental Health Section, Division of Public Health, N.C. Department of Health and Human Services, 1632 Mail Service Center, Raleigh, NC 27699-1632.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017;
Amended Eff. October 1, 2019.

10A NCAC 13B .4906 BLOOD BANK

(a) Facilities which provide for procurement, storage and transfusion of blood shall meet the standards of the American Association of Blood Banks as outlined in the most current edition of Standards of Blood Banks and Transfusion Services, which is incorporated by reference, including all subsequent amendments and additions, and which is available from the American Association of Blood Banks, 8101 Glenbrook Road, Bethesda, Maryland 20814-2749 at a cost of thirty-three dollars and fifty cents ($33.50) per copy.
(b) The governing body shall approve the pathologist or physician as physician-in-charge of the blood bank service.
(c) Records shall be kept on file indicating the receipt and disposition of all blood handled. Care shall be taken to ascertain that blood administered has not exceeded its expiration date, and meets all criteria for safe administration.
(d) The facility shall make arrangements to secure on short notice all necessary supplies of blood, typed and cross-matched as required, for emergencies.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .4907 MORGUE AND AUTOPSY FACILITIES

(a) Morgue and autopsy services shall be provided either on site or by written agreement with a facility that provides those services.
(b) Procedures for the transport and storage of deceased patients shall be established and maintained by the facility.
(c) Procedures for post mortem cleaning of patients with diagnosed contagious diseases shall be established and maintained by the facility.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

SECTION .5000 - PHYSICAL REHABILITATION SERVICES

10A NCAC 13B .5001 ORGANIZATION

The facility shall designate an individual responsible for the administration and supervision of each rehabilitation service.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5002 DELIVERY OF CARE

(a) A member of the medical staff shall be responsible for the general medical care of the inpatient.
(b) The delivery of all rehabilitation services shall be provided by practitioners credentialed or licensed in their respective fields.

History Note: *Authority G.S. 131E-79;*
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5003 POLICIES AND PROCEDURES

The facility shall establish and maintain written policies and procedures that include but are not limited to:

(1) provision for assessment and evaluation of the services performed;
(2) safety measures;
(3) infection control measures; and
(4) procedures for referral to other facilities for services not available on site.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5004 PATIENT RECORDS

The patient record shall contain documentation of physical rehabilitation services utilized that include but is not limited to:

(1) diagnosis to support the services requested;
(2) assessment of patient's rehabilitative status;
(3) re-assessment and progress of patient's rehabilitative status;
(4) individualized plan of care and goals of rehabilitation; and
(5) discharge plan.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5005 CARDIAC REHABILITATION PROGRAM

When a facility elects to provide an outpatient cardiac rehabilitation program, the program shall be subject to 10 NCAC 3S, Sections .0300 - .1000, which are incorporated by reference with all subsequent amendments. Referenced rules are available from the North Carolina Department of Health and Human Services, Division of Health Service Regulation, Licensure and Certification Section, 2711 Mail Service Center, Raleigh, NC 27699 at a cost of three dollars ($3.00) each.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

SECTION .5100 - INFECTION CONTROL

10A NCAC 13B .5101 ORGANIZATION

(a) The governing body shall establish and maintain an infection control program that includes all patient care and patient care support services and departments for the surveillance, prevention and control of infection.

(b) The infection control committee shall include representatives of the medical staff, nursing staff, administration and the person directly responsible for the surveillance program activities.

(c) The infection control committee shall assume responsibility for the infection control program.

(d) The facility shall designate a person to manage the infection control, prevention and surveillance program.

(e) The infection control committee shall involve facility departments and services as needed to maintain the infection control program.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5102 POLICY AND PROCEDURES

(a) Each facility department or service shall establish and maintain the following written infection control policies and procedures:

(1) the role and scope of the service or department in the infection control program;
(2) the role and scope of surveillance activities in the infection control program;
(3) the methodology used to collect and analyze data, maintain a surveillance program on nosocomial infection, and the control and prevention of infection;
(4) the specific precautions to be used to prevent the transmission of infection and isolation methods to be utilized;
(5) the method of sterilization and storage of equipment and supplies, including the reprocessing of disposable items;
(6) the cleaning of patient care areas and equipment;
(7) the cleaning of non-patient care areas; and
(8) exposure control plans.

(b) The infection control committee shall approve all infection control policies and procedures. The committee shall review all policies and procedures every three years and indicate the last date of review.

(c) The infection control committee shall meet quarterly and maintain minutes of meetings.

History Note: Authority G.S. 143B-165;
Eff. January 1, 1996;
Readopted Eff August 1, 2023.

10A NCAC 13B .5103 LAUNDRY SERVICE

The facility shall provide, directly or by contract, a laundry service or department that provides the following:

(1) 24 hour a day availability of clean linen for patient care needs; and
(2) delivery of clean linen and removal of soiled linen in a manner that reduces the spread of infection.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5104 ENVIRONMENTAL SERVICES

The facility shall require that environmental services (housekeeping) provide the following:

(1) 24 hour a day availability of personnel or supplies and equipment for the cleaning of patient rooms, patient care equipment, and the cleaning of spills;
(2) a routine cleaning schedule for all areas of the facility to assist in the prevention and spread of disease; and
(3) removal and appropriate disposal of waste materials including biologicals.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5105 STERILE SUPPLY SERVICES

The facility shall provide for the following:

(1) decontamination and sterilization of equipment and supplies;
(2) monitoring of sterilizing equipment on a routine schedule;
(3) establishment of policies and procedures for the use of disposable items; and
(4) establishment of policies and procedures addressing shelf life of stored sterile items.

History Note: Authority G.S. 143B-165;
Eff. January 1, 1996;
Readopted Eff. August 1, 2023.

SECTION .5200 - PSYCHIATRIC SERVICES

10A NCAC 13B .5201 PSYCHIATRIC OR SUBSTANCE ABUSE SERVICES: APPLICABILITY OF RULES

The rules contained in this Section shall apply to all psychiatric and substance abuse services provided by any facility.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5202 DEFINITIONS APPLICABLE TO PSYCHIATRIC OR SUBSTANCE ABUSE SERVICES

(a) "Certified counselor" means an alcoholism, drug abuse or substance abuse counselor who is certified by the North Carolina Substance Abuse Professional Certification Board.
(b) "Certified substance abuse counselor/supervisor" means an individual who is a "certified counselor" as defined in 10 NCAC 3C .5202(a) and is designated by the North Carolina Substance Abuse Professional Certification Board as a qualified substance abuse supervisor.
(c) "Clinical/professional supervision" means regularly scheduled assistance by a qualified mental health, professional or a qualified substance abuse professional to a staff member who is providing direct, therapeutic intervention to a client or clients. The purpose of clinical supervision is to ensure that each client receives appropriate treatment or habilitation which is consistent with accepted standards of practice and the needs of the client.
(d) "Detoxification service" means a unit or department whose primary purpose is the medical management or care of persons who are under the influence of alcohol or drugs.
(e) "Direct care staff" means an individual who provides active direct care, treatment, or rehabilitation or habilitation services to clients on a continuous and regularly scheduled basis.
(f) "Psychiatric nurse" means an individual who is licensed to practice as a registered nurse in North Carolina by the North Carolina Board of Nursing; and has:

(1) a graduate degree from an accredited master's level program in psychiatric mental health nursing with two years of experience; or
(2) a master's degree in behavioral science with two years of supervised clinical experience in psychiatric mental health nursing; or
(3) a baccalaureate degree in behavioral science with four years of supervised clinical experience in psychiatric mental health nursing.

(g) "Psychiatric service" means an inpatient or outpatient unit or department whose primary purpose is the treatment of mental illness. It also means the mental health treatment provided in such a unit or department.
(h) "Psychiatric social worker" means an individual who holds a master's degree in social work from an accredited school of social work and has two years of clinical social work experience.

(i) "Psychiatrist" means an individual who is licensed to practice medicine in North Carolina and who has completed an accredited training program in psychiatry.
(j) "Psychologist" means an individual licensed to practice psychology in North Carolina by the North Carolina State Board of Examiners of Practicing Psychologists.
(k) "Qualified mental health professional" means any one of the following: psychiatrist, psychiatric nurse, practicing psychologist, psychiatric social worker, an individual with at least a masters degree in a related human service field and two years of supervised clinical experience in mental health services or an individual with a baccalaureate degree in a related human service field and four years of supervised clinical experience in mental health services.
(l) "Qualified substance abuse professional" means an individual who is:

(1) certified by the North Carolina Substance Abuse Professional Certification Board;
(2) certified by the National Consortium of Chemical Dependency Nurses, Inc;
(3) certified by the National Nurses Society on Addictions; or
(4) a graduate of a college or university with a baccalaureate or advanced degree in a human service related field with documentation of at least two years of supervised experience in the profession of alcoholism and drug abuse counseling.

(m) "Restraint" means the limitation of one's freedom of movement and includes the following:

(1) mechanical restraint which means restraint of a client with the intent of controlling behavior with mechanical devices which include, but are not limited to, cuff, ankle straps, sheets or restraining shirts; or
(2) physical restraint which means restraint of a client until calm. As used in these Rules, the term physical restraint does not apply to the use of professionally recognized methods for therapeutic holds of brief duration (five minutes or less).

(n) "Restrictive facility" means a facility so designated by the Division of Health Service Regulation which uses mechanical restraint or seclusion in accordance with G.S. 122C-60 in order to restrain a client's freedom of movement.
(o) "Seclusion" means isolating a client in a separate locked room for the purpose of controlling a client's behavior.
(p) "Substance abuse service" means inpatient or outpatient unit or department whose primary purpose is the treatment of chemical dependency. It also means the chemical dependency treatment provided in such a unit or department.

History Note: *Authority G.S. 131E-79;*
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5203 STAFFING FOR PSYCHIATRIC OR SUBSTANCE ABUSE SERVICES

(a) General Requirements:

(1) A physician shall be present in the facility or on call 24 hours per day. The medical appraisal and medical treatment of each patient shall be the responsibility of a physician;
(2) Each facility shall determine its overall staffing requirements based upon the age categories (child, adolescent, adult, elderly), clinical characteristics, treatment requirements and numbers of patients;
(3) There shall be a sufficient number of appropriately qualified clinical and support staff to assess and address the clinical needs of the patients;
(4) Staff members shall have training or experience in the provision of care in each of the age categories assigned for treatment.

(b) Psychiatric Services:

(1) Staff coverage for psychiatric services shall include at least one each of the following: psychiatrist, psychiatric nurse, psychologist, and psychiatric social worker;
(2) A qualified mental health professional shall be available by telephone or page and able to reach the facility within 30 minutes on a 24 hour basis;
(3) Each clinical or direct care staff member who is not a qualified mental health professional shall receive professional supervision from a qualified mental health professional;
(4) When detoxification services are provided, there shall be liaison and consultation with a qualified substance abuse professional prior to the discharge of a client.

(c) Substance Abuse Services:

(1) At least one registered nurse shall be on duty during each shift;

(2) Certified substance abuse counselors or qualified substance abuse professionals shall be employed at the ratio of one staff member for each 10 inpatients or fraction thereof. In documented instances of bona fide shortages of certified persons, uncertified individuals expecting to become certified may be employed for a maximum of 38 months without qualifications;

(3) The facility shall have a minimum of two staff members providing care, treatment and services directly to patients on duty at all times and maintain a shift ratio of one staff member for each 20 or less inpatients with the following exceptions:

(A) When there are minor inpatients there shall be staff available on the ratio of one staff member for each five minor inpatients or fraction thereof during each shift from 7:00 a.m. - 11:00 p.m.;

(B) When detox services are offered there shall be no less than one staff member for each nine inpatients or fraction thereof on each shift.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5204 PSYCHIATRIC OR SUBSTANCE ABUSE SERVICES RECORD REQUIREMENTS

(a) In addition to the general record keeping requirements of 10A NCAC 13B .3906, specialized assessment and treatment plans for individuals undergoing psychiatric or substance abuse treatment are as follows:

(1) Within 24 hours following admission each individual shall have a completed admission assessment. The initial assessment shall include the reason for admission, admitting diagnosis, mental status including suicide potential, diagnostic tests or evaluations, and a determination of the need for additional information to include the potential for the physical abuse of self or others and a family assessment when a minor is involved;

(2) Within 72 hours following admission, a preliminary individual treatment plan shall be completed and implemented; and

(3) Within five days following admission, a comprehensive individual treatment plan shall be developed and implemented. For outpatient services, the plan shall be developed and implemented within 30 days of admission to treatment.

(b) Individual treatment plans for psychiatric and substance abuse patients shall be developed in partnership with the patient or individual acting on behalf of the patient. Clinical responsibility for the development and implementation of the plan shall be clearly designated. Minimum components of the comprehensive treatment plan shall include diagnosis and time specific short and long term measurable goals, strategies for reaching goals, and staff responsibility for plan implementation. The plan shall be revised as medically or clinically indicated.

(c) Progress notes shall be entered in each individual's record. Included is information which may have a significant impact on the individual's condition or expected outcome such as family conferences or major events related to the patient. Patient status shall be documented each shift for any inpatient psychiatric or substance abuse services, and on a per visit basis for outpatient psychiatric and substance abuse services.

(d) For each individual to whom substance abuse services are provided, a written plan for aftercare services shall be developed which minimally includes:

(1) plan for delivering aftercare services, including the aftercare services which are provided; and

(2) provision for agreements with individuals or organizations if aftercare services are not provided directly by the facility.

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5205 SECLUSION

At least one seclusion room shall be provided in all hospitals licensed to provide a psychiatric program, a substance abuse program or both.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5206 COMPLIANCE WITH STATUTORY REQUIREMENTS

(a) Facilities providing psychiatric or substance abuse services shall develop procedures to protect the rights of psychiatric and substance abuse patients in accordance with North Carolina statutes addressing the rights of psychiatric and substance abuse patients. Statutes addressing such rights are as follows:

(1) G.S. 122C-51. Declaration of policy on clients' rights;
(2) G.S. 122C-52. Right to confidentiality;
(3) G.S. 122C-53. Exceptions; client;
(4) G.S. 122C-54. Exceptions; abuse reports and court proceedings;
(5) G.S. 122C-55. Exceptions; care and treatment;
(6) G.S. 122C-56. Exceptions; research and planning;
(7) G.S. 122C-57. Right to treatment and consent to treatment;
(8) G.S. 122C-58. Civil rights and civil remedies;
(9) G.S. 122C-59. Use of corporal punishment;
(10) G.S. 122C-60. Use of physical restraints or seclusion;
(11) G.S. 122C-61. Treatment rights in 24-hour facilities;
(12) G.S. 122C-62. Additional rights in 24-hour facilities;
(13) G.S. 122C-65. Offenses relating to clients; and
(14) G.S. 122C-66. Protection from abuse and exploitation; reporting.

(b) Facilities providing psychiatric or substance abuse services shall develop procedures to protect confidentiality of information regarding communicable disease and conditions in compliance with G.S. 130A-143.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5207 PSYCHIATRIC OR SUBSTANCE ABUSE OUTPATIENT SERVICES

Partial hospitalization, outpatient and day treatment facilities shall be subject to 10A NCAC 27G .1100, 10A NCAC 27G .3500, and 10A NCAC 27G .3700 respectively, which are incorporated by reference with all subsequent amendments. Referenced rules are available from the N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Advocacy, Client Rights and Quality Improvement Section, 3009 Mail Service Center, Raleigh, NC 27699-3009 at a cost of five dollars and seventy-five cents ($5.75) per copy.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

SECTION .5300 - NURSING AND ADULT CARE HOME BEDS

10A NCAC 13B .5301 THE LICENSURE OF NURSING AND ADULT CARE HOME BEDS IN A HOSPITAL

When a facility has nursing facility beds or adult care home beds, the beds shall be provided under the hospital's license as provided in Rule .3101 of this Subchapter. The nursing facility beds and the adult care home beds shall be subject to the rules in 10A NCAC 13D with the exception that the following rules shall not apply: 10A NCAC 13D .2001(4); .2101 - .2108; .2201; .2208; .2209; .2211; .2212; .2302; .2401; .2402; .2503; .2504; .2602; .2607; .2701; and .2901. With these exceptions, the rules in 10A NCAC 13D are incorporated by reference with all subsequent

amendments. Referenced rules are available from the NC Division of Health Service Regulation, 2711 Mail Service Center, Raleigh, N.C. 27699-2711 at a cost of six dollars ($6.00) per copy.

History Note: *Authority G.S. 131E-79;*
Eff. March 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017;
Amended Eff. October 1, 2019.

SECTION .5400 - COMPREHENSIVE INPATIENT REHABILITATION

10A NCAC 13B .5401 DEFINITIONS

The following definitions shall apply to inpatient rehabilitation facilities or units only:

(1) "Case management" means the coordination of services, for a given patient, between disciplines so that the patient may reach optimal rehabilitation through the judicious use of resources.

(2) "Comprehensive, inpatient rehabilitation program" means a program for the treatment of persons with functional limitations or chronic disabling conditions who have the potential to achieve a significant improvement in activities of daily living. A comprehensive, rehabilitation program shall utilize a coordinated and integrated, interdisciplinary approach, directed by a physician, to assess patient needs and to provide treatment and evaluation of physical, psycho-social and cognitive deficits.

(3) "Inpatient rehabilitation facility or unit" means a free-standing facility or a unit (unit pertains to contiguous dedicated beds and spaces) approved in accordance with G.S. 131E, Article 9 to establish inpatient, rehabilitation beds and to provide a comprehensive, inpatient rehabilitation program within an existing licensed health service facility.

(4) "Medical consultations" means consultations which the rehabilitation physician or the attending physician determine are necessary to meet the acute medical needs of the patient and do not include routine medical needs.

(5) "Occupational therapist" means any individual licensed in the State of North Carolina as an occupational therapist in accordance with the provisions of G.S. 90, Article 18D.

(6) "Occupational therapist assistant" means any individual licensed in the State of North Carolina as an occupational therapist assistant in accordance with the provisions of G.S. 90, Article 18D.

(7) "Psychologist" means a person licensed as a practicing psychologist in accordance with G.S. 90, Article 18A.

(8) "Physiatrist" means a licensed physician who has completed a physical medicine and rehabilitation residency training program approved by the Accreditation Council of Graduate Medical Education or the American Osteopathic Association.

(9) "Physical therapist" means any person licensed in the State of North Carolina as a physical therapist in accordance with the provisions of G.S. 90, Article 18B.

(10) "Physical therapist assistant" means any person licensed in the State of North Carolina as a physical therapist assistant in accordance with the provisions of G.S. 90-270.24, Article 18B.

(11) "Recreational therapist" means a person certified by the State of North Carolina Therapeutic Recreational Certification Board.

(12) "Rehabilitation aide" means an unlicensed assistant who works under the supervision of a registered nurse, licensed physical therapist or occupational therapist in accordance with the appropriate occupational licensure laws governing his or her supervisor and consistent with staffing requirements as set forth in Rule .5508 of this Section. The rehabilitation aide shall be listed on the North Carolina Nurse Aide Registry and have received additional staff training as listed in Rule .5509 of this Section.

(13) "Rehabilitation nurse" means a registered nurse licensed in North Carolina, with training, either academic or on-the-job, in physical rehabilitation nursing and at least one year experience in physical rehabilitation nursing.

(14) "Rehabilitation physician" means a physiatrist or a physician who is qualified, based on education, training and experience regardless of specialty, of providing medical care to rehabilitation patients.

(15) "Social worker" means a person certified by the North Carolina Social Work Certification and Licensure Board in accordance with G.S. 90B-3.

(16) "Speech and language pathologist" means any person licensed in the State of North Carolina as a speech and language pathologist in accordance with the provisions of G.S. 90, Article 22.

History Note: Authority G.S. 131E-79;
RRC Objection due to lack of statutory authority Eff. January 18, 1996;
Eff. May 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5402 PHYSICIAN REQUIREMENTS FOR INPATIENT REHABILITATION FACILITIES OR UNITS

(a) In a rehabilitation facility or unit, a physician shall participate in the provision and management of rehabilitation services and in the provision of medical services.
(b) In a rehabilitation facility or unit, a rehabilitation physician shall be responsible for a patient's interdisciplinary treatment plan. Each patient's interdisciplinary treatment plan shall be developed and implemented under the supervision of a rehabilitation physician.
(c) The rehabilitation physician shall participate in the preliminary assessment within 48 hours of admission, prepare a plan of care and direct the necessary frequency of contact based on the medical and rehabilitation needs of the patient. The frequency shall be appropriate to justify the need for comprehensive inpatient rehabilitation care.
(d) An inpatient rehabilitation facility or unit's contract or agreements with a rehabilitation physician shall require that the rehabilitation physician shall participate in individual case conferences or care planning sessions and shall review and sign discharge summaries and records. When patients are to be discharged to another health care facility, the discharging facility shall ensure that the patient has been provided with a discharge plan which incorporates post discharge continuity of care and services. When patients are to be discharged to a residential setting, the facility shall ensure that the patient has been provided with a discharge plan that incorporates the utilization of community resources when available and when included in the patient's plan of care.
(e) The intensity of physician medical services and the frequency of regular contacts for medical care for the patient shall be determined by the patient's pathophysiologic needs.
(f) Where the attending physician of a patient in an inpatient rehabilitation facility or unit orders medical consultations for the patient, such consultations shall be provided by qualified physicians within 48 hours of the physician's order. In order to achieve this result, the contracts or agreements between inpatient rehabilitation facilities or units and medical consultants shall require that such consultants render the requested medical consultation within 48 hours.
(g) An inpatient rehabilitation facility or unit shall have a written procedure for setting the qualifications of the physicians, rendering physical rehabilitation services in the facility or unit.

History Note: Authority G.S. 131E-79;
RRC Objection due to lack of statutory authority Eff. January 18, 1996;
Eff. May 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5403 ADMISSION CRITERIA FOR INPATIENT REHABILITATION FACILITIES OR UNITS

(a) The facility shall have written criteria for admission to the inpatient rehabilitation facility or unit. A description of programs or services for screening the suitability of a given patient for placement shall be available to staff and referral sources.
(b) For patients found unsuitable for admission to the inpatient rehabilitation facility or unit, there shall be documentation of the reasons.
(c) Within 48 hours of admission, a preliminary assessment shall be completed by members of the interdisciplinary team to insure the appropriateness of placement and to identify the immediate needs of the patients.
(d) Patients admitted to an inpatient rehabilitation facility or unit must be able to tolerate a minimum of three hours of rehabilitation therapy, five days a week, including at least two of the following rehabilitation services: physical therapy, occupational therapy or speech therapy.
(e) Patients admitted to an inpatient rehabilitation facility or unit must be medically stable, have a prognosis indicating a progressively improved medical condition and have the potential for increased independence.

History Note: *Authority G.S. 131E-79;*
Eff. March 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5404 COMPREHENSIVE INPATIENT REHABILITATION EVALUATION

(a) A comprehensive, inpatient rehabilitation evaluation is required for each patient admitted to an inpatient rehabilitation facility or unit. At a minimum this evaluation shall include the reason for referral, a summary of the patient's clinical condition, functional strengths and limitations, and indications for specific services. This evaluation shall be completed within three days.
(b) Each patient shall be evaluated by the interdisciplinary team to determine the need for any of the following services: medical, dietary, occupational therapy, physical therapy, prosthetics and orthotics, psychological assessment and therapy, therapeutic recreation, rehabilitation medicine, rehabilitation nursing, therapeutic counseling or social work, vocational rehabilitation evaluation and speech-language pathology.

History Note: *Authority G.S. 131E-79;*
Eff. March 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5405 COMPREHENSIVE INPATIENT REHABILITATION INTER-DISCIPLINARY TREAT/PLAN

(a) The interdisciplinary treatment team shall develop an individual treatment plan for each patient within seven days after admission. The plan shall include evaluation findings and information about the following:
(1) prior level of function;
(2) current functional limitations;
(3) specific service needs;
(4) treatment, supports and adaptations to be provided;
(5) specified treatment goals;
(6) disciplines responsible for implementation of separate parts of the plan; and
(7) anticipated time frames for the accomplishment of specified long-term and short-term goals.

(b) The treatment plan shall be reviewed by the interdisciplinary team at least every other week. All members of the interdisciplinary team, or a representative of their discipline, shall attend each meeting. Documentation of each review shall include progress toward defined goals and identification of any changes in the treatment plan.
(c) The treatment plan shall include provisions for all of the services identified as needed for the patient in the comprehensive inpatient rehabilitation evaluation completed in accordance with Rule .5404 of this Section.
(d) Each patient shall have a designated case manager who shall be responsible for the coordination of the patient's individualized treatment plan. The case manager shall be responsible for promoting the program's responsiveness to the needs of the patient and shall participate in all team conferences concerning the patient's progress toward the accomplishment of specified goals. Any of the professional staff involved in the patient's care may be the designated case manager for one or more cases.

History Note: *Authority G.S. 131E-79;*
Eff. March 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5406 DISCHARGE CRITERIA FOR INPATIENT REHABILITATION FACILITIES OR UNITS

(a) Discharge planning shall be an integral part of the patient's treatment plan and shall begin upon admission to the facility. After goals of care have been reached, or a determination by the interdisciplinary care team has been made to return to the setting from which the patient was admitted, or that further progress is unlikely, the patient shall be discharged to another inpatient or residential health care facility that can address the patient's needs including skilled nursing homes, assisted living facilities, nursing homes, or other hospitals. Other reasons for discharge may include an inability or unwillingness of patient or family to cooperate with the planned therapeutic program or medical

complications that preclude a further intensive rehabilitative effort. The facility shall involve the patient, family, staff members, and community-based services such as home health services, hospice or palliative care, respiratory services, rehabilitation services to include occupational therapy, physical therapy, and speech therapy, end stage renal disease, nutritional, medical equipment and supplies, transportation services, meal services, and household services such as housekeeping in discharge planning.
(b) The case manager shall facilitate the discharge or transfer process in coordination with the facility social worker.
(c) If a patient is being referred to another facility for further care, documentation of the patient's current status shall be forwarded with the patient. A discharge summary shall be forwarded within 48 hours following discharge and shall include the reasons for referral, the diagnosis, functional limitations, services provided, the results of services, referral action recommendations, and activities and procedures used by the patient to maintain and improve functioning.

History Note: *Authority G.S. 143B-165;*
Eff. March 1, 1996;
Readopted Eff. August 1, 2023.

10A NCAC 13B .5407 COMPREHENSIVE REHABILITATION PERSONNEL ADMINISTRATION
(a) The facility shall have qualified staff members, consultants and contract personnel to provide services to the patients admitted to the inpatient rehabilitation facility or unit.
(b) Personnel shall be employed or provided by contractual agreement in sufficient types and numbers to meet the needs of all patients admitted for comprehensive rehabilitation.
(c) Written agreements shall be maintained by the facility when services are provided by contract on an ongoing basis.

History Note: *Authority G.S. 131E-79;*
RRC Objection due to lack of statutory authority Eff. January 18, 1996;
Eff. May 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5408 COMPREHENSIVE INPATIENT REHABILITATION PROGRAM STAFFING REQUIREMENTS
(a) The staff of the inpatient rehabilitation facility or unit shall include:
(1) the inpatient rehabilitation facility or unit shall be supervised by a rehabilitation nurse as defined in Rule .5401 of this Section. The facility shall assign staff qualified to meet the needs of the patient;
(2) the minimum nursing hours per patient in the rehabilitation unit shall be 5.5 nursing hours per patient day. At no time shall direct care nursing staff be less than two full-time equivalents, one of which must be a registered nurse;
(3) the inpatient rehabilitation unit shall employ or provide by contractual agreements therapists to provide three hours of specific (physical, occupational or speech) or combined rehabilitation therapy services per patient day;
(4) rehabilitation aides shall have documented training appropriate to the activities to be performed and the occupational licensure laws of his or her supervisor. Supervision by the physical therapist or by the occupational therapist is limited to that time when the therapist is on-site and directing the rehabilitation activities of the aide; and
(5) hours of service by the rehabilitation aide are counted toward the required nursing hours when the aide is working under the supervision of the nurse. Hours of service by the rehabilitation aide are counted toward therapy hours during that time the aide works under the immediate, on-site supervision of the physical therapist or occupational therapist. Hours of service shall not be dually counted for both services. Hours of service by rehabilitation aides in performing nurse-aide duties in areas of the facility other than the rehabilitation unit shall not be counted toward the 5.5 hour minimum nursing requirement described for the rehabilitation unit.
(b) Additional personnel shall be provided as required to meet the needs of the patient, as defined in the comprehensive inpatient rehabilitation evaluation.

History Note: Authority G.S. 143B-165;
RRC Objection due to lack of statutory authority Eff. January 18, 1996;
Eff. May 1, 1996;
Readopted Eff. August 1, 2023.

10A NCAC 13B .5409 STAFF TRAINING FOR INPATIENT REHABILITATION FACILITIES OR UNIT

Prior to the provision of care, all rehabilitation personnel, excluding physicians, assigned to the rehabilitation unit shall be provided training or shall provide documentation of training that includes at a minimum the following:

(1) active and passive range of motion;
(2) assistance with ambulation;
(3) transfers;
(4) maximizing functional independence;
(5) the psycho-social needs of the rehabilitation patient;
(6) the increased safety risks of rehabilitation training (including falls and the use of restraints);
(7) proper body mechanics;
(8) nutrition, including dysphagia and restorative eating;
(9) communication with the aphasic and hearing impaired patient;
(10) behavior modification;
(11) bowel and bladder training; and
(12) skin care.

History Note: Authority G.S. 131E-79;
RRC Objection due to lack of statutory authority Eff. January 18, 1996;
Eff. May 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5410 EQUIPMENT REQUIREMENTS/COMPREHENSIVE INPATIENT REHABILITATION PROGRAMS

(a) The facility shall provide each discipline with the necessary equipment and treatment methods to achieve the short and long-term goals specified in the comprehensive inpatient rehabilitation interdisciplinary treatment plans for patients admitted to these facilities or units.
(b) Each patient's needs for a standard wheelchair or a specially designed wheelchair or additional devices to allow safe and independent mobility within the facility shall be met.
(c) Special physical therapy and occupational therapy equipment for use in fabricating positioning devices for beds and wheelchairs shall be provided including splints, casts, cushions, wedges and bolsters.
(d) Physical therapy devices shall be provided, including a mat, table, parallel bars, sliding boards, and special adaptive bathroom equipment.

History Note: Authority G.S. 131E-79;
Eff. March 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5411 PHYSICAL FACILITY REQUIREMENTS/INPATIENT REHABILITATION FACILITIES OR UNIT

History Note: Authority G.S. 143B-165;
Eff. March 1, 1996;
Repealed Eff. August 1, 2023.

10A NCAC 13B .5412 ADDITIONAL REQUIREMENTS FOR TRAUMATIC BRAIN INJURY PATIENTS

(a) Inpatient rehabilitation facilities providing services to patients with traumatic brain injuries shall provide staff to meet the needs of patients in accordance with the patient assessment, treatment plan, and physician orders.

(b) The facility shall provide special equipment to meet the needs of patients with traumatic brain injury, including specially designed wheelchairs, tilt tables and standing tables.
(c) The facility shall provide the consulting services of a neuropsychologist.
(d) The facility shall provide continuing education in the care and treatment of brain injury patients for all staff.

History Note: Authority G.S. 131E-79;
RRC Objection due to lack of statutory authority Eff. January 18, 1996;
Eff. May 1, 1996;
Readopted Eff. April 1, 2020.

10A NCAC 13B .5413 ADDITIONAL REQUIREMENTS FOR SPINAL CORD INJURY PATIENTS
(a) Inpatient rehabilitation facilities providing services to patients with spinal cord injuries shall provide staff to meet the needs of patients in accordance with the patient assessment, treatment plan, and physician orders.
(b) The facility shall provide special equipment to meet the needs of patients with spinal cord injury, including specially designed wheelchairs, tilt tables and standing tables.
(c) The facility shall provide continuing education in the care and treatment of spinal cord injury patients for all staff.
(d) The facility shall provide specific staff training and education in the care and treatment of spinal cord injury.

History Note: Authority G.S. 131E-79;
RRC Objection due to lack of statutory authority Eff. January 18, 1996;
Eff. May 1, 1996;
Readopted Eff. April 1, 2020.

10A NCAC 13B .5414 DEEMED STATUS FOR INPATIENT REHABILITATION FACILITIES OR UNIT
(a) If an inpatient rehabilitation facility or unit with a comprehensive inpatient rehabilitation program is surveyed and accredited by The Joint Commission (TJC) or the Commission on Accreditation of Rehabilitation Facilities (CARF) and has been approved by the Department in accordance with G.S. 131E, Article 9, the Department deems the facility to be in compliance with Rules .5401 through .5413 of this Section.
(b) Deemed status shall be provided only if the inpatient rehabilitation facility or unit provides copies of survey reports to the Department. The TJC report shall show that the facility or unit was surveyed for rehabilitation services. The CARF report shall show that the facility or unit was surveyed for comprehensive rehabilitation services. The facility or unit shall sign an agreement (Memorandum of Understanding) with the Department specifying these terms.
(c) The inpatient rehabilitation facility or unit shall be subject to inspections or complaint investigations by representatives of the Department at any time. If the facility or unit is found not to be in compliance with the rules listed in Paragraph (a) of this Rule, the facility shall submit a plan of correction and be subject to a follow-up visit to ensure compliance.
(d) If the inpatient rehabilitation facility or unit loses or does not renew its accreditation, the facility or unit shall notify the Division in writing within 30 days.

History Note: Authority G.S. 131E-79;
Eff. March 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017;
Amended Eff. October 1, 2019.

SECTION .5500 – SUPPLEMENTAL RULES FOR HOSPITALS PROVIDING LIVING ORGAN DONATION TRANSPLANT SERVICES

10A NCAC 13B .5501 APPLICABILITY OF RULES
The rules contained in this Section shall apply to hospitals providing living organ donation transplant services.

History Note: Authority G.S. 131E-75; 131E-79; 143B-165;
Eff. April 1, 2006;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5502 INDEPENDENT DONOR ADVOCATE TEAM

(a) The facility shall appoint an Independent Donor Advocate Team (IDAT) whose sole purpose is to represent and ensure the well-being of the potential donor, making sure he or she is aware of the risks and benefits of donation and that the choice to donate is voluntary. The IDAT shall ensure the potential donor learns about the entire donation process. This would include the selection of recipients for the transplant, the procedures to be employed for both the donor and recipient, and possible outcomes. Sufficient time for the discussion, supplemented with written materials, must be allowed for comprehension and assimilation of the information about transplantation and the ramifications of donation. Written and verbal presentations shall be in language in accordance with the person's ability to understand.

(b) The IDAT shall consist of a physician, a clinical transplant coordinator, and a social worker or qualified mental health professional as defined in Rule .5202(k) of this Subchapter. The physician shall be the leader of the IDAT. The IDAT members shall have experience in organ transplantation processes and programs and shall be able to act for the interests of the potential donor independent of any financial or facility influence. Based on the outcome of the evaluation of the potential donor pursuant to Rule .5504 of this Section, if the IDAT determines any potential donor is unsuitable for donation, it shall provide the reasons both verbally and in writing.

(c) In order to ensure the well-being of the potential donor, the IDAT shall:

(1) Protect and represent the interests of the potential donor;

(2) Make it clear to the potential donor that the choice to donate is entirely his or hers;

(3) Inform and discuss with the potential donor the medical, psychosocial and financial aspects related to the live donation;

(4) Explain to the potential donor the evaluation process, what it means and his or her option to stop at any time;

(5) Determine the intellectual and emotional ability of the potential donor to understand the legal and ethical aspects of informed choice;

(6) Assess if the potential donor has understood the risks and the benefits and how they impact on his or her own core beliefs and values; and

(7) Identify for the potential donor resources that will be available to provide continuous care during hospitalization and referrals in medicine, psychiatry or social work, which may be needed or required following discharge.

History Note: Authority G.S. 131E-75; 131E-79; 143B-165;
Eff. May 1, 2006;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5503 INFORMED CHOICE

(a) The potential donor must be free to make an informed independent decision, which has been termed informed choice. Informed choice addresses the decision process of the potential donor as he or she determines whether or not to donate. Informed choice has several aspects. First, the potential donor must know he or she has a choice, meaning he or she can freely decide either to donate or not to donate an organ. Second, the potential donor must be aware of both the risks and benefits of donation. The potential donor must be able to weigh the positive aspects of the donation as well as take into account the technical aspects such as the surgery, recovery, financial impact and any unexpected but potential consequences that may result such as a change in the patient's life, health, insurability, employment or emotional stability.

(b) The person who consents to be a live organ donor shall be:

(1) Legally competent;

(2) Willing to donate;

(3) Free from coercion, including financial coercion, actual or implied;

(4) Medically suitable;

(5) Informed and able to express understanding of the risks and benefits of donation; and

(6) Informed of the risks, benefits and alternative treatment regimens available to the recipient.

(c) A statement signed by the potential donor that his or her participation is completely voluntary and may be withdrawn at any time shall be placed in the medical record.

(d) Understanding

(1) The potential donor shall be able to demonstrate that he or she understands the essential elements of the donation process with emphasis on the risks associated with the procedure;

(2) With the potential donor's permission, the donor's designee, family or next of kin shall be given the opportunity to openly discuss the donor's concerns in a safe and non-threatening environment; and

(3) The potential donor shall understand, agree to, and commit to postoperative follow-up and testing by the facility performing the surgical removal of the organ and subsequent organ transplant.

(e) Disclosure

(1) The donor surgical team and the IDAT shall disclose any facility affiliations to the potential donor;

(2) The potential donor shall have a period of reflection appropriate to the acuity of the clinical condition of the recipient and reaffirmation of the decision to donate subsequent to the completion of the medical work-up and final approval to proceed by the IDAT. After the period of reflection the potential donor may sign the consent for the donation procedure;

(3) Non-English speaking candidates and hearing impaired candidates must be provided with a non-family interpreter who understands the donor's language and culture;

(4) A member of the IDAT shall witness the potential donor signing the consent documents for removal of the donor organ; and

(5) The overall donation process and experience shall be explained to the potential donor and shall be provided in writing to include:

(A) Donor evaluation procedure;

(B) Surgical procedure;

(C) Recuperative period;

(D) Short-term and long term follow-up care;

(E) Alternative donation and transplant procedure;

(F) Potential psychological benefits to donor;

(G) Transplant facility and surgeon-specific statistics of donor and recipient outcomes;

(H) Confidentiality of the donor's information and decisions;

(I) Donor's ability to opt out at any point in the process;

(J) Information about how the facility performing the transplant will attempt to follow the health of the donor; and

(K) Need for the donor to review potential personal insurability for future insurance coverage.

(f) The IDAT shall make the potential donor aware of the following risk factors:

(1) Physical

(A) Potential for surgical complications including risk of donor death;

(B) Potential for organ failure and the need for future organ transplant for the donor;

(C) Potential for other medical complications including long-term complications and complications currently unforeseen;

(D) Scars;

(E) Pain;

(F) Fatigue; and

(G) Abdominal or bowel symptoms such as bloating and nausea.

(2) Psychosocial

(A) Potential for problems with body image;

(B) Possibility of transplant recipient death;

(C) Possibility of transplant recipient rejection and need for re-transplantation;

(D) Possibility of recurrent disease in a transplant recipient;

(E) Possibility of post surgery adjustment problems;

(F) Impact on the donor's family or next of kin;

(G) Impact on the transplant recipient's family or next of kin; and

(H) Potential impact of donation on the donor's lifestyle.

(3) Financial

(A) Out of pocket expenses;

(B) Child care costs;

(C) Possible loss of employment;
(D) Potential impact on the ability to obtain future employment; and
(E) Potential impact on the ability to obtain or afford health and life insurance.

(g) The potential donor shall provide assurance and consent that the following areas have been addressed:

(1) That there is no monetary profit to the potential donor. Coverage for expenses incurred as a result of the organ donation is not considered monetary profit;
(2) That family members or others did not coerce the potential donor into making his or her decision;
(3) That the potential donor has been provided with a general statement of unsuitability for donation if requested. Medical information regarding the potential donor shall not be falsified to provide the donor with an excuse to decline donation;
(4) That the potential donor is intellectually and emotionally capable of participation in a discussion of potential risks and benefits;
(5) That the potential donor has been provided adequate information to ensure his or her understanding regarding the risks of the donation;
(6) That the potential donor has been educated regarding the recipient's options for organs from deceased persons, including risks and outcomes; and
(7) That the potential donor understands that he or she may decline to donate at any time.

(h) Documentation

(1) A medical record, separate and distinct from the transplant recipient's record, shall be maintained to protect donor confidentiality; and
(2) The informed choice process and evaluation protocol shall be documented and placed in the potential donor's medical record.

(i) Decision to Donate. Once the IDAT determines the suitability of the potential donor the IDAT shall discuss with the potential donor's surgical team and transplant team its decision prior to its presentation to the potential donor. If the potential donor wishes to donate, but the IDAT does not agree, the IDAT's opposition shall be so noted in a report to the donor surgeon, who shall document reasons for proceeding against the IDAT advice. The reason why the IDAT has objections shall be explained to the potential donor. For example, the potential donor may not have the ability to understand the information provided to him or her or the donor may be unable to integrate the degree of risk pertinent to his or her situation or there may be a lack of balance between the risks to the potential donor and potential benefits to the transplant recipient. Even if the potential donor is willing to donate his or her organ, the final review and decision whether or not to proceed with the donation rests with the donor surgical team and transplant team.

(j) In cases involving living liver donation, prior to reaching a decision to donate the potential donor shall be provided in writing the U.S. Department of Health and Human Services Advisory Committee on Organ Transplantation (ACOT) recommendations entitled "Living Liver Donor Initial Consent for Evaluation" which is hereby incorporated by reference with all subsequent amendments. The ACOT recommendations can be obtained free of charge via the internet at: http://www.organdonor.gov/acotrecs.html. The items contained in the ACOT recommendations must be explained to the potential donor in language and terms which he or she can understand and then be signed by the donor and the signature witnessed. Subsequent to this, if all the facts show that the potential donor is, in fact, in all respects a viable potential donor, then he or she shall execute the ACOT recommended form entitled "Living Liver Donor Informed Consent for Surgery" which is hereby incorporated by reference with all subsequent amendments. In addition, this form shall comply with G.S. 90-21.13 Informed Consent which is hereby incorporated by reference with all subsequent amendments.

History Note: *Authority G.S. 131E-75; 131E-79; 143B-165;*
Eff. May 1, 2006;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5504 EVALUATION PROTOCOL FOR LIVING ORGAN DONORS

Hospitals shall complete the following evaluation protocols prior to living organ donation:

(1) The facility shall confirm the potential donor's ABO blood type.
(2) Only individuals 18 years of age or older shall be considered for living organ donation. The facility shall complete a screening interview with the potential donor which confirms the donor's age, height, weight, demographic information, medical and surgical history, medications, drug or alcohol history, smoking history, and a family or social history. Insurance issues (health and life)

shall also be discussed with the potential donor and an attempt shall be made to answer any questions asked by the donor. Written information on the living donor process shall be made available to the potential donor.

(3) The donor surgical team shall determine whether the potential donor shall be excluded based on the medical information or family history: for example, exclusionary criteria may include the presence of diabetes, uncontrolled hypertension, liver, pulmonary or cardiac disease, renal dysfunction or high Body Mass Index (BMI).

(4) An IDAT shall be assigned for the potential donor pursuant to Rule .5502(c) of this Section. The IDAT leader shall not be a physician who is the primary physician of the potential transplant recipient.

(5) The IDAT leader shall conduct a medical evaluation of the potential donor. The medical evaluation shall include a full and frank discussion of the risks associated with the evaluation tests with the potential donor and the donor's chosen designee. If the potential donor wishes to proceed, laboratory and diagnostic tests shall be ordered as necessary.

(6) An IDAT member shall conduct a psychosocial evaluation of the potential donor. The IDAT member shall also discuss financial considerations.

(7) The IDAT shall review the laboratory and diagnostic test results, as well as psychosocial evaluation and discuss them with the donor to decide whether to move forward with the potential donor's evaluation.

(8) The donor surgeon shall evaluate the mortality and morbidity risks associated with donation and disclose those risks to the potential donor with adequate time for any questions to be answered in detail. The donor's designee shall also be present at this appointment.

(9) The IDAT shall perform a final review and makes its recommendation as set out in Rule .5503(i) of this Section.

(10) The hospital shall schedule an appointment for pre-operative screening with the potential donor after the entire process of evaluation is complete. An informed consent as required in Rule .4605(c)(2) of this Subchapter is necessary for the donation and surgical procedure and shall be completed by this time. In addition, where applicable, the potential donor shall be given ample time for autologous blood donation through the American Red Cross.

History Note: *Authority G.S. 131E-75; 131E-79; 143B-165;*
Eff. May 1, 2006;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5505 PERIOPERATIVE CARE AND FACILITY SUPPORT

(a) The donor surgical team shall have primary concern and responsibility for the donor's care and welfare throughout his or her entire hospital stay. The donor surgical team consists of the donor surgeon, his or her surgical and medical partners, fellows, residents, and physician assistants or nurse practitioners.

(b) Preoperative Preparation

(1) The facility shall have the ability to allow donors to bank a minimum of one unit of blood before surgery. Facilities shall have the ability to store and transfuse autologous blood;

(2) The transplant coordinator or another team member shall be assigned the responsibility of providing updates to the families of both the donor and transplant recipient during the surgical procedures; and

(3) For live donor liver procedures, surgeries shall be scheduled only when staffing will be available for the postoperative period. If surgery is scheduled on a Thursday or Friday, the hospital shall ensure that there is adequate attending physician, resident physician, physician assistant or nurse practitioner, and registered nursing coverage during the weekend.

(c) Postoperative Care

(1) After live donor nephrectomy, the patient shall receive post-operative care equivalent to that provided for abdominal procedures under general anesthesia; and

(2) For live liver donors:

(A) Day 0-1: The live adult liver donor shall receive care in the intensive care unit (ICU) or post-anesthesia care unit (PACU);

(B) Day 2: If stable and cleared for transfer by the donor surgical team, the donor shall be cared for in a hospital unit that is dedicated to the care of transplant recipients or a hospital unit in which patients who undergo hepatobiliary resectional surgery are provided care. Liver donors shall not at any time be cared for on any other unit unless a specific medical condition of the donor warrants such a transfer;

(C) The donor shall be evaluated at least daily by a liver transplant attending physician with documentation in the medical record;

(D) The donor surgical team shall be responsible for the clinical management of the donor;

(E) The patient care staff shall be familiar with the common complications associated with the donor and transplant recipient operations and have appropriate monitoring in place to detect these problems if they arise; and

(F) If there is an emergent complication requiring re-operation, these patients shall be prioritized for access to the operating room based on the facility's operating room policies and guidelines.

(d) Medical Staffing. For live donor nephrectomy patients, there shall be continuous physician coverage available for patient evaluation as needed. These patients shall be provided post-operative care equivalent to patients undergoing a nephrectomy.

(e) Nurse Staffing

(1) Nursing staff shall be familiar with recovery of nephrectomy patients. They shall be aware of the signs and symptoms of hypovolemia due to post-operative bleeding or to excessive diuresis. They shall have ready access to the surgical team responsible for the patient's post-operative care;

(2) For live liver donors, nursing staff shall have ongoing education and training in live donor liver transplantation nursing care for both donors and recipients. This shall include education on the pain management issues particular to the donor. The registered nursing to patient ratio in the ICU or PACU level setting shall be appropriate for the acuity level of the patients. For live liver donors, the same registered nurse shall not take care of both the donor and the recipient. For live liver donors, the nursing service shall provide the potential donor with pre-surgical information including, if possible, a tour of the unit before surgery; and

(3) For all donors, the names and beeper numbers of the donor surgical team or team responsible for the donor's post-operative surgical care (e.g. urology service or laparoscopic general surgery service for some donor nephrectomy patients) shall be posted on all units receiving transplant donors.

(f) Radiology. For facilities performing live donor nephrectomies, radiological staff shall be available for pre-operative assessment, peri-operative care, and post-operative follow-up as required.

History Note: Authority G.S. 131E-75; 131E-79; 143B-165;
Eff. April 1, 2006;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

10A NCAC 13B .5506 DISCHARGE PLANNING

(a) Pre-Donation. At the time of evaluation by the IDAT, a discussion shall be held between the IDAT social worker and the potential donor and his or her family or next of kin to address the following areas:

(1) Living arrangements after discharge from the surgery or while the donor recuperates until able to travel;

(2) Transportation arrangements from the hospital to the donor's accommodations or back to follow up appointments;

(3) Caregivers to provide assistance or support upon discharge; if the donor has children or other dependents, a plan for the children's or dependent's care while the donor recuperates;

(4) Financial considerations: Encourage donor to discuss with employer about medical leave or disability. This discussion shall include checking with health or life insurance carriers about future "pre-existing conditions" or "exclusions" that may result from donation;

(5) Provided consent is first obtained, referrals to other living organ donors from that particular facility and suggestions from other resources such as publications and websites; and

(6) Emotional issues surrounding the organ donation process.

(b) Day of Discharge

(1) A written discharge plan shall be provided to the donor with the following instructions:
   (A) Restrictions on activities;
   (B) Permitted activities (i.e. return to work);
   (C) Diet;
   (D) Pain medication with prescription;
   (E) Follow up appointments with surgeon;
   (F) Contact numbers for the Independent Donor Advocate Team should the donor have questions, concerns or problems; and
   (G) Additional instructions for caregivers, if any.
(2) The discharge plan shall be reviewed with the donor by the facility discharge planner or primary care nurse.

(c) Post Discharge medical follow-up, social, psychological and financial support
(1) Post-operative visits shall be scheduled by the donor with the surgeon to assess the following:
   (A) Wound healing;
   (B) Signs and symptoms of infections; and
   (C) Laboratory results as appropriate to the organ type, as well as any imaging or other diagnostic findings.
(2) Dictated summaries of surgery and follow-up visits shall be sent to the donor's primary care physician by the facility to ensure appropriate medical care.
(3) Referrals shall be made to community agencies to address the donor's emotional and psychological issues if needed or requested by the donor, his or her designee, family, next of kin or the IDAT to;
   (A) Provide the donor the opportunity to participate in a support group; and
   (B) Provide the donor recognition as determined by the facility.

(d) Any questions or concerns regarding the discharge plan or discharge planning process by the donor, the donor's designee, the donor's next of kin or legally responsible party shall be addressed by facility staff.

History Note: *Authority G.S. 131E-75; 131E-79; 143B-165;*
Eff. April 1, 2006;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. July 22, 2017.

SECTION .5600 - RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .5600 RESERVED FOR FUTURE CODIFICATION

SECTION .5700 - RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .5700 RESERVED FOR FUTURE CODIFICATION

SECTION .5800 - RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .5800 RESERVED FOR FUTURE CODIFICATION

SECTION .5900 - RESERVED FOR FUTURE CODIFICATION

10A NCAC 13B .5900 RESERVED FOR FUTURE CODIFICATION

SECTION .6000 - PHYSICAL PLANT

10A NCAC 13B .6001 LOCATION
10A NCAC 13B .6002 ROADS AND PARKING

History Note: *Authority G.S. 131E-79;*
Eff. January 1, 1996;
Repealed Eff. January 1, 2018.

10A NCAC 13B .6003 DEFINITIONS

In addition to the definitions set forth in G.S. 131E-76, the following definitions shall apply in Sections .6000 through .6200 of this Subchapter:

(1) "Addition" means an extension or increase in floor area or height of a building.

(2) "Alteration" means any construction or renovation to an existing building other than construction of an addition.

(3) "Construction documents" means final building plans and specifications for the construction of a facility that a governing body submits to the Construction Section for approval as specified in Rule .3102 of this Subchapter.

(4) "Construction Section" means the Construction Section of the Division of Health Service Regulation.

(5) "Division" means the Division of Health Service Regulation of the North Carolina Department of Health and Human Services.

(6) "Facility" means a hospital as defined in G.S. 131E-76.

History Note: *Authority G.S. 131E-76; 131E-79; S.L. 2017-174;*
Temporary Adoption Eff. December 1, 2017;
Eff. March 21, 2019

SECTION .6100 – GENERAL REQUIREMENTS

10A NCAC 13B .6101 LIST OF REFERENCED CODES, RULES, REGULATIONS, AND STANDARDS

For the purposes of the rules in this Subchapter, the following codes, rules, regulations, and standards are incorporated herein by reference including subsequent amendments and editions. Copies of these codes, rules, regulations, and standards may be obtained or accessed from the online addresses listed:

(1) the North Carolina State Building Codes with copies that may be purchased from the International Code Council online at http://shop.iccsafe.org/ at a cost of five hundred seventy-one dollars ($571.00) or accessed electronically free of charge at http://codes.iccsafe.org/North%20Carolina.html;

(2) 42 CFR Part 482.41, Condition of Participation: Physical Plant, that is incorporated herein by reference including all subsequent amendments and editions; however, Part 482.41(c)(1) shall not be incorporated by reference. Copies of this regulation may be accessed free of charge at https://www.gpo.gov/fdsys/pkg/CFR-2017-title42-vol5/xml/CFR-2017-title42-vol5-sec482-41.xml or purchased online at https://bookstore.gpo.gov/products/cfr-title-42-pt-482-end-code-federal-regulationspaper-201-7 for a cost of seventy-seven dollars ($77.00);

(3) the following National Fire Protection Association standards, codes, and guidelines with copies of these standards, codes, and guidelines that may be accessed electronically free of charge at https://www.nfpa.org/Codes-and-Standards/All-Codes-and-Standards/List-of-Codes-and-Standards or may be purchased online at https://catalog.nfpa.org/Codes-and-Standards-C3322.aspx for the costs listed:

   (a) NFPA 22, Standard for Water Tanks for Private Fire Protection for a cost of fifty-four dollars ($54.00);

   (b) NFPA 53, Recommended Practice on Materials, Equipment, and Systems Used in Oxygen-Enriched Atmospheres for a cost of fifty-three dollars ($53.00);

   (c) NFPA 59A, Standard for the Production, Storage, and Handling of Liquefied Natural Gas for a cost of fifty-four dollars ($54.00);

   (d) NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials for a cost of forty-two dollars ($42.00);

   (e) NFPA 407, Standard for Aircraft Fuel Servicing for a cost of forty-nine dollars ($49.00);

   (f) NFPA 705, Recommended Practice for a Field Flame Test for Textiles and Films for a cost of forty-two dollars ($42.00);

   (g) NFPA 780, Standard for the Installation of Lightning Protection Systems for a cost of sixty-three dollars and fifty cents ($63.50);

   (h) NFPA 801, Standard for Fire Protection for Facilities Handling Radioactive Materials for a cost of forty-nine dollars ($49.00); and

(i) Fire Protection Guide to Hazardous Materials for a cost of one hundred and thirty-five dollars and twenty-five cents ($135.25);

(4) 42 CFR Part 482.15 Condition of participation: Emergency preparedness with copies of this regulation that may be accessed free of charge at https://www.gpo.gov/fdsys/pkg/CFR-2017-title42-vol5/xml/CFR-2017-title42-vol5-sec482-15.xml or purchased online at https://bookstore.gpo.gov/products/cfr-title-42-pt-482-end-code-federal-regulationspaper-201-7 for a cost of seventy-seven dollars ($77.00);

(5) the "Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes, and Other Institutions" 15A NCAC 18A .1300 with copies of these rules that may be accessed electronically free of charge at http://reports.oah.state.nc.us/ncac/title%2015a%20-%20environmental%20quality/chapter%2018%20-%20environmental%20health/subchapter%20a/15a%20ncac%2018a%20.1301.pdf; and

(6) the rules for ambulatory surgical facilities in 10A NCAC 13C, Licensing of Ambulatory Surgical Facilities with copies of these rules that may be accessed electronically free of charge at http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2013%20-%20nc%20medical%20care%20commission/subchapter%20c/subchapter%20c%20rules.pdf.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Readopted Eff. April 1, 2019.

10A NCAC 13B .6102 GENERAL

(a) A new facility or any addition or alteration to an existing facility whose construction documents were approved by the Construction Section on or after April 1, 2019 shall comply with the requirements provided in the codes, regulations, rules, and standards incorporated by reference in Rule .6101(1) through (3) of this Section. An existing facility whose construction documents were approved by the Construction Section prior to April 1, 2019 shall comply with the codes, regulations, rules, and standards incorporated by reference in Rule .6101(1) through (3) of this Section that were in effect at the time construction documents were approved by the Construction Section.

(b) The facility shall develop and maintain an emergency preparedness program as required by 42 CFR Part 482.15 Condition of Participation: Emergency Preparedness. The emergency preparedness program shall be developed with input from the local fire department and local emergency management agency. Documentation required to be maintained by 42 CFR Part 482.15 shall be maintained at the facility for at least three years and shall be made available to the Division during an inspection upon request.

(c) The facility shall comply with the "Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes, and Other Institutions," 15A NCAC 18A .1300 of the North Carolina Division of Public Health, Environmental Health Services Section.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Readopted Eff. April 1, 2019.

10A NCAC 13B .6103 EQUIVALENCY AND CONFLICTS WITH REQUIREMENTS

(a) The Division may grant an equivalency to allow an alternate design or functional variation from the requirements in Rule .3102 and the Rules contained in Sections .6000 through .6200 of this Subchapter. The equivalency may be granted by the Division if a governing body submits a written equivalency request to the Division that states the following:

(1) the rule citation and the rule requirement that will not be met;

(2) the justification for the equivalency; and

(3) how the proposed equivalency meets the intent of the corresponding rule requirement.

In determining whether to grant an equivalency request the Division shall consider whether the request will reduce the safety and operational effectiveness of the facility design and layout. The governing body shall maintain a copy of the approved equivalence issued by the Division.

(b) If the rules, codes, or standards contained in this Subchapter conflict, the most restrictive requirement shall apply.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Readopted Eff. April 1, 2019.

10A NCAC 13B .6104 ACCESS AND SAFETY

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Repealed Eff. January 1, 2018.

10A NCAC 13B .6105 INCORPORATION BY REFERENCE AND APPLICATION OF THE REQUIREMENTS OF THE FGI GUIDELINES

(a) For the purposes of Sections .6000 through .6200 of this Subchapter, the Guidelines for the Design and Construction of Hospitals and Outpatient Facilities shall be referred to as the FGI Guidelines.
(b) The FGI Guidelines are incorporated herein by reference, including all subsequent amendments and editions; however, the following chapters of the FGI Guidelines shall not be incorporated herein by reference:
(1) Chapter 3.1;
(2) Chapter 3.2;
(3) Chapter 3.3;
(4) Chapter 3.4;
(5) Chapter 3.5;
(6) Chapter 3.6;
(7) Chapter 3.7;
(8) Chapter 3.8;
(9) Chapter 3.9;
(10) Chapter 3.10;
(11) Chapter 3.11;
(12) Chapter 3.12; and
(13) Chapter 3.14.
(c) The FGI Guidelines incorporated by this Rule may be purchased from the Facility Guidelines Institute online at https://www.fgiguidelines.org/guidelines-main/purchase/ at a cost of two hundred dollars ($200.00) or accessed electronically free of charge at https://www.fgiguidelines.org/guidelines-main/.
(d) A new facility or any additions or alterations to an existing facility whose construction documents were approved by the Construction Section on or after January 1, 2018 shall meet the requirements set forth in:
(1) Sections .6000 through .6200 of this Subchapter; and
(2) the edition of the FGI Guidelines that was in effect at the time the construction documents were approved by the Construction Section.
(e) An existing facility whose construction documents were approved by the Construction Section prior to January 1, 2018 shall meet those standards established in Sections .6000 through .6200 of this Subchapter that were in effect at the time the construction documents were approved by the Construction Section.
(f) Any existing building converted from another use to a new facility shall meet the requirements of Paragraph (d) of this Rule.
(g) Previous versions of the Rules of Sections .6000 through .6200 of this Subchapter can be accessed online at https://www.ncdhhs.gov/dhsr/const/index.html.

History Note: Authority G.S. 131E-79; S.L. 2017-174;
Temporary Adoption Eff. December 1, 2017;
Eff. March 21, 2019.

SECTION .6200 - CONSTRUCTION REQUIREMENTS

10A NCAC 13B .6201 MEDICAL, SURGICAL AND POST-PARTUM CARE UNIT
10A NCAC 13B .6202 SPECIAL CARE UNIT
10A NCAC 13B .6203 NEONATAL LEVEL I AND LEVEL II NURSERY UNIT
10A NCAC 13B .6204 NEONATAL LEVEL III AND LEVEL IV NURSERY
10A NCAC 13B .6205 PSYCHIATRIC UNIT

10A NCAC 13B .6206 SURGICAL DEPARTMENT REQUIREMENTS

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Amended Eff. November 1, 2004;
Repealed Eff. January 1, 2018.

10A NCAC 13B .6207 OUTPATIENT SURGICAL FACILITIES

(a) If a facility elects to share outpatient surgical facilities with inpatient surgical facilities, the outpatient operating room and support areas shall meet the requirements set forth in Sections .6000 through .6200 of this Subchapter.
(b) If a facility elects to provide separate, non-sharable outpatient surgical facilities, the operating rooms and support areas shall meet the requirements set forth in 10A NCAC 13C .1400.

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Readopted Eff. April 1, 2019.

10A NCAC 13B .6208 OBSTETRICAL DEPARTMENT SERVICES
10A NCAC 13B .6209 EMERGENCY SERVICES
10A NCAC 13B .6210 IMAGING SERVICES
10A NCAC 13B .6211 LABORATORY SERVICES
10A NCAC 13B .6212 MORGUE
10A NCAC 13B .6213 PHARMACY SERVICES
10A NCAC 13B .6214 DIETARY SERVICES
10A NCAC 13B .6215 ADMINISTRATION
10A NCAC 13B .6216 MEDICAL RECORDS SERVICES
10A NCAC 13B .6217 CENTRAL MEDICAL AND SURGICAL SUPPLY SERVICES
10A NCAC 13B .6218 GENERAL STORAGE
10A NCAC 13B .6219 LAUNDRY SERVICES
10A NCAC 13B .6220 PHYSICAL REHABILITATION SERVICES
10A NCAC 13B .6221 ENGINEERING SERVICES
10A NCAC 13B .6222 WASTE PROCESSING
10A NCAC 13B .6223 DETAILS AND FINISHES
10A NCAC 13B .6224 ELEVATOR REQUIREMENTS
10A NCAC 13B .6225 MECHANICAL REQUIREMENTS
10A NCAC 13B .6226 PLUMBING AND OTHER PIPING SYSTEMS REQUIREMENTS
10A NCAC 13B .6227 ELECTRICAL REQUIREMENTS

History Note: Authority G.S. 131E-79;
Eff. January 1, 1996;
Amended July 1, 1996;
Repealed Eff. January 1, 2018.

10A NCAC 13B .6228 NEONATAL LEVEL I, II, III, AND IV NURSERIES

A facility that provides neonatal services as specified in Rule .4305 of this Subchapter shall meet the requirements of the FGI Guidelines as follows:

(1) a Neonatal Level I nursery shall comply with the requirements of Sections 2.2-2.12 Nursery Unit and 2.2-2.12.3.1 Newborn Nursery;
(2) a Neonatal Level II nursery shall comply with the requirements of Sections 2.2-2.12 Nursery Unit and 2.2-2.12.3.3 Continuing Care Nursery;
(3) a Neonatal Level III nursery shall comply with the requirements of Section 2.2-2.10 Neonatal Intensive Care Unit; and
(4) a Neonatal Level IV nursery shall comply with the requirements of Section 2.2-2.10 Neonatal Intensive Care Unit.

History Note: Authority G.S. 131E-79; S.L. 2017-174;

Temporary Adoption Eff. December 1, 2017;
Eff. March 21, 2019.

SUBCHAPTER 13C – LICENSING OF AMBULATORY SURGICAL FACILITIES

SECTION .0100 – GENERAL

10A NCAC 13C .0101 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13C .0102 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13C .0103 DEFINITIONS

In addition to the terms defined in G.S. 131E-214.13, the following terms shall apply throughout this Subchapter, unless the context clearly requires otherwise:

(1) "Adequate" means, when applied to various areas of services, that the services are satisfactory in meeting a referred to need when measured against professional standards of practice.
(2) "AAAASF" means American Association for Accreditation of Ambulatory Surgery Facilities.
(3) "AAAHC" means Accreditation Association for Ambulatory Health Care.
(4) "Ancillary nursing personnel" means persons employed to assist registered nurses or licensed practical nurses in the care of patients.
(5) "Anesthesiologist" means a physician whose specialized training and experience qualify him or her to administer anesthetic agents and to monitor the patient under the influence of these agents. For the purpose of this Subchapter, the term "anesthesiologist" shall not include podiatrists.
(6) "Anesthetist" means a physician or dentist qualified, as defined in Items (10) and (24) of this Rule, to administer anesthetic agents or a registered nurse qualified, as defined in Items (25) and (27) of this Rule, to administer anesthesia.
(7) "Authority having jurisdiction" means the Division of Health Service Regulation.
(8) "Chief executive officer" or "administrator" means a qualified person appointed by the governing authority to act in its behalf in the overall management of the facility and whose office is located in the facility.
(9) "Current Procedural Terminology (CPT)" means a medical code set developed by the American Medical Association.
(10) "Dentist" means a person who holds a valid license issued by the North Carolina Board of Dental Examiners to practice dentistry.
(11) "Department" means the North Carolina Department of Health and Human Services.
(12) "Director of nursing" means a registered nurse who is responsible to the chief executive officer or administrator and has the authority and direct responsibility for all nursing services and nursing care for the entire facility at all times.
(13) "Financial assistance" means a policy, including charity care, describing how the organization will provide assistance at its facility. Financial assistance includes free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are unable to pay for all or a portion of the services. Financial assistance does not include:
    (a) bad debt;
    (b) uncollectable charges that the organization recorded as revenue but wrote off due to a patient's failure to pay;
    (c) the cost of providing such care to the patients in Sub-Item (13)(b) of this Rule; or
    (d) the difference between the cost of care provided under Medicare or other government programs, and the revenue derived therefrom.
(14) "Governing authority" means the individual, agency, group, or corporation appointed, elected, or otherwise designated, in which the ultimate responsibility and authority for the conduct of the ambulatory surgical facility is vested.
(15) "Healthcare Common Procedure Coding System (HCPCS)" means a three tiered medical code set consisting of Level I, II and III services and contains the CPT code set in Level I.

(16) "JCAHO" or "Joint Commission" means Joint Commission on Accreditation of Healthcare Organizations.
(17) "Licensing agency" means the Department of Health and Human Services, Division of Health Service Regulation.
(18) "Licensed practical nurse (L.P.N.)" means any person licensed as such under the provisions of G.S. 90-171.20(8).
(19) "Nursing personnel" means registered nurses, licensed practical nurses, and ancillary nursing personnel.
(20) "Operating room" means a room in which surgical procedures are performed.
(21) "Patient" means a person admitted to and receiving care in a facility.
(22) "Person" means an individual, a trust or estate, a partnership or corporation, including associations, joint stock companies and insurance companies; the State, or a political subdivision or instrumentality of the state.
(23) "Pharmacist" means a person who holds a valid license issued by the North Carolina Board of Pharmacy to practice pharmacy in accordance with G.S. 90-85.3A.
(24) "Physician" means a person who holds a valid license issued by the North Carolina Medical Board to practice medicine. For the purpose of carrying out these Rules, a "physician" may also mean a person holding a valid license issued by the North Carolina Board of Podiatry Examiners to practice podiatry.
(25) "Qualified person," when used in connection with an occupation or position, means a person:
    (a) who has demonstrated through experience the ability to perform the required functions; or
    (b) who has certification, registration, or other professional recognition.
(26) "Recovery area" means a room used for the post-anesthesia recovery of surgical patients.
(27) "Registered nurse" means a person who holds a valid license issued by the North Carolina Board of Nursing to practice nursing as defined in G.S. 90-171.20(7).
(28) "Surgical suite" means an area that includes one or more operating rooms and one or more recovery rooms.

History Note: *Authority G.S. 131E-149; 131E-214.13;*
Eff. October 14, 1978;
Amended Eff. April 1, 2003; November 1, 1989;
Temporary Amendment Eff. December 31, 2014;
Amended Eff. September 30, 2015;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

SECTION .0200 - LICENSING PROCEDURES

10A NCAC 13C .0201 APPLICATION

(a) A person shall submit an application for a license to establish or maintain an ambulatory surgical facility to the Department in writing on the form provided by the Department. Each application shall contain all necessary and reasonable information that the Department may by rule require, including the following and other pertinent information the Department may deem appropriate to carry out its responsibilities for statistical data collection and long range health planning:
(1) name of facility,
(2) address of facility,
(3) telephone number of facility,
(4) names of owners,
(5) names of operator and governing authority,
(6) name of chief executive officer,
(7) composition of medical and paramedical staff,
(8) name of chief of staff,
(9) director of nursing service,
(10) number of operating rooms and recovery beds,
(11) list of surgical procedures to be performed in facility,

(12) qualification of persons responsible for anesthesia services,
(13) information regarding use and storage of flammable anesthesia,
(14) description of laboratory and pathology services,
(15) name of hospital(s) with which transfer agreement has been made,
(16) description of arrangements for emergency transportation of patients from the facility,
(17) description of arrangements for food service, and
(18) information regarding sanitation inspection and fire inspection.

(b) The person shall make application for a license for a new facility or for the renewal of a license for an existing facility. Applications for licensure for a new facility shall be submitted at least 120 days prior to opening.

(c) Any ambulatory surgical facility desiring licensure which is in operation at the time of promulgation of any applicable rules or regulations shall be given a reasonable time, not to exceed one year from the date of such promulgation, within which to comply with such rules and regulations.

History Note: Authority G.S. 131E-147; 131E-149;
Eff. October 14, 1978;
Amended Eff. November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .0202 REQUIREMENTS FOR ISSUANCE OF LICENSE

(a) Upon application for a license from a facility never before licensed, a representative of the Department shall make an inspection of that facility. Every building, institution, or establishment that has been issued a license shall be inspected for compliance with the rules found in this Subchapter. An ambulatory surgery facility shall be deemed to meet licensure requirements if the ambulatory surgery facility is accredited by The Joint Commission, AAAHC, or AAAASF. Accreditation shall not exempt a facility from statutory or rule requirements for licensure nor shall it prohibit the Department from conducting inspections as provided in this Rule to determine compliance with all requirements.

(b) If the applicant has been issued a Certificate of Need and is found to be in compliance with the rules found in this Subchapter, then the Department shall issue a license to expire on December 31 of each year.

(c) The Department shall be notified at the time of:
(1) any change of the owner or operator;
(2) any change of location;
(3) any change as to a lease; and
(4) any transfer, assignment, or other disposition or change of ownership or control of 20 percent or more of the capital stock or voting rights thereunder of a corporation that is the operator or owner of an ambulatory surgical facility, or any transfer, assignment, or other disposition of the stock or voting rights thereunder of such corporation that results in the ownership or control of more than 20 percent of the stock or voting rights thereunder of such corporation by any person.

A new application shall be submitted to the Department in the event of such a change or changes.

(d) The Department shall not grant a license until the plans and specifications that are stated in Section .1400 of this Subchapter, covering the construction of new buildings, additions, or material alterations to existing buildings are approved by the Department.

(e) The facility design and construction shall be in accordance with the licensure rules for ambulatory surgical facilities found in this Subchapter, the North Carolina State Building Code, and local municipal codes.

(f) Submission of Plans.
(1) When construction or remodeling of a facility is planned, one copy of construction documents and specifications shall be submitted by the owner or owner's appointed representative to the Department for review and approval. Schematic design drawings and design development drawings may be submitted for approval prior to the required submission of construction documents.
(2) Approval of construction documents and specifications shall be obtained from the Department prior to licensure. Approval of construction documents and specifications shall expire one year after the date of approval unless a building permit for the construction has been obtained prior to the expiration date of the approval of construction documents and specifications.
(3) The plans shall include a plot plan showing the size and shape of the entire site and the location of all existing and proposed facilities.

(g) To qualify for licensure or license renewal, each facility shall provide to the Division, with its application, an attestation statement in a form provided by the Division verifying compliance with the requirements defined in Rule .0301(d) of this Subchapter.

History Note: *Authority G.S. 131E-91; 131E-147; 131E-149;*
Eff. October 14, 1978;
Amended Eff. April 1, 2003;
Temporary Amendment Eff. May 1, 2014;
Amended Eff. November 1, 2014;
Readopted Eff. January 1, 2021.

10A NCAC 13C .0203 SUSPENSION OR REVOCATION: AMBULATORY SURGICAL FACILITY
License suspensions and revocations shall be governed by G.S. 131E-148.

History Note: *Authority G.S. 131E-148; 131E-149; 143B-165;*
Eff. October 14, 1978;
Amended Eff. November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017;
Amended Eff. January 1, 2021.

10A NCAC 13C .0204 TYPE OF FACILITY DEEMED TO BE LICENSED
An ambulatory surgical facility shall be deemed a suitable facility for the performance of abortions pursuant to G.S. 14-45.1(a).

History Note: *Authority G.S. 14-45.1; 131E-147; 131E-149;*
Eff. June 30, 1980;
Amended Eff. November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .0205 ITEMIZED CHARGES
(a) The facility shall either present an itemized list of charges to all discharged patients or include on patients' bills that are not itemized notification of the right to request an itemized bill within three years of receipt of the non-itemized bill or so long as the facility, collections agency, or other assignee asserts the patient has an obligation to pay the bill.
(b) If requested, the facility shall present an itemized list of charges to each patient or his or her representative. This list shall detail in language comprehensible to an ordinary layperson the specific nature of the charges or expenses incurred by the patient.
(c) The listing shall include each specific chargeable item or service in the following service areas:
(1) Surgery (facility fee);
(2) Anesthesiology;
(3) Pharmacy;
(4) Laboratory;
(5) Radiology;
(6) Prosthetic and Orthopedic appliances; and
(7) Other professional services.
(d) The facility shall indicate on the initial or renewal license application that patient bills are itemized, or that each patient or his or her representative is formally advised of the patient's right to request an itemized listing within three years of receipt of a non-itemized bill.

History Note: *Authority G.S. 131E-91; 131E-147.1; S.L. 2013-382, s. 13.1;*
Eff. December 1, 1991;
Temporary Amendment Eff. May 1, 2014;
Amended Eff. November 1, 2014;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .0206 REPORTING REQUIREMENTS

(a) The Department shall establish the lists of the statewide 20 most common outpatient imaging procedures and 20 most common outpatient surgical procedures performed in the ambulatory surgical facility setting to be used for reporting the data required in Paragraphs (c) and (d) of this Rule. The lists shall be determined annually based upon data provided by the certified statewide data processor. The Department shall make the lists available on its website. The methodology to be used by the certified statewide data processor for determining the lists shall be based on the data collected from all licensed facilities in the State in accordance with G.S. 131E-214.2 as follows:

(1) the 20 most common imaging procedures shall be based upon all outpatient data for ambulatory surgical facilities and represent all occurrences of the diagnostic radiology imaging codes section of the CPT codes, then selecting the top 20 to be provided to the Department; and

(2) the 20 most common outpatient surgical procedures shall be based upon the primary procedure code from the ambulatory surgical facilities and represent all occurrences of the surgical codes section of the CPT codes, then selecting the top 20 to be provided to the Department.

(b) All information required by this Rule shall be posted on the Department's website at: http://www.ncdhhs.gov/dhsr/ahc and may be accessed at no cost.

(c) In accordance with G.S. 131E-214.13, all licensed ambulatory surgical facilities shall report the data required in Paragraph (d) of this Rule related to the statewide 20 most common outpatient imaging procedures and the statewide 20 most common outpatient surgical procedures to the certified statewide data processor in a format provided by the certified statewide processor. This report shall include the related primary CPT and HCPCS codes. Commencing with the reporting period ending September 30, 2015, an annual data report shall be submitted. Each annual report shall be submitted by January 1.

(d) The report as described in Paragraph (c) of this Rule shall be specific to each reporting ambulatory surgical facility and shall include:

(1) the average gross charge for each CPT code or procedure without a public or private third party payer source;

(2) the average negotiated settlement on the amount that will be charged for each CPT code or procedure as required for patients defined in Subparagraph (d)(1) of this Rule. The average negotiated settlement shall be calculated using the average amount charged all patients eligible for the facility's financial assistance policy, including self-pay patients;

(3) the amount of Medicaid reimbursement for each CPT code or procedure, including all supplemental payments to and from the ambulatory surgical facility;

(4) the amount of Medicare reimbursement for each CPT code or procedure; and

(5) on behalf of patients who are covered by a Department of Insurance licensed third-party and teachers and State employees, the lowest, average, and highest amount of payments made for each CPT code or procedure by each of the facility's top five largest health insurers.

    (A) each ambulatory surgical facility shall determine its five largest health insurers based on the dollar volume of payments received from those insurers;

    (B) the lowest amount of payment shall be reported as the lowest payment from each of the five insurers on the CPT code or procedure;

    (C) the average amount of payment shall be reported as the arithmetic average of each of the five health insurers payment amounts;

    (D) the highest amount of payment shall be reported as the highest payment from each of the five insurers on the CPT code or procedure; and

    (E) the identity of the top five largest health insurers shall be redacted prior to submission.

(e) The data reported, as defined in Paragraphs (c) and (d) of this Rule, shall reflect the payments received from patients and health insurers for all closed accounts. For the purpose of this Rule, "closed accounts" are patient accounts with a zero balance at the end of the data reporting period.

(f) A minimum of three data elements shall be required for reporting under Paragraph (c) of this Rule.

(g) The information submitted in the report shall be in compliance with the federal Health Insurance Portability and Accountability Act of 45 CFR Part 164.

(h) The Department shall provide all specific ambulatory surgical facility data reported pursuant to this Rule on its website.

History Note: Authority G.S. 131E-147.1; 131E-214.4; 131E-214.13;
Temporary Adoption Eff. December 31, 2014;
Eff. September 30, 2015;
Temporary Amendment Eff. March 31, 2016;
Amended Eff. January 31, 2017.

SECTION .0300 – GOVERNING AUTHORITY MANAGEMENT

10A NCAC 13C .0301 GOVERNING AUTHORITY

(a) The facility's governing authority shall adopt bylaws or other operating policies and procedures to assure that:

(1) a named individual is identified who is responsible for the overall operation and maintenance of the facility. The governing authority shall have methods in place for the oversight of the individual's performance;

(2) annual meetings of the governing authority shall be conducted if the governing authority consists of two or more individuals. Minutes shall be maintained of such meetings;

(3) a policy and procedure manual is created that is designed to ensure professional and safe care for the patients. The manual shall be reviewed annually and revised in accordance with facility policy. The manual shall include provisions for administration and use of the facility, compliance, personnel quality assurance, procurement of outside services and consultations, patient care policies, and services offered; and

(4) annual reviews and evaluations of the facility's policies, management, and operation are conducted.

(b) When services such as dietary, laundry, or therapy services are purchased from others, the governing authority shall be responsible for assuring the supplier meets the same local and State standards the facility would have to meet if it were providing those services using its own staff.

(c) The governing authority shall provide for the selection and appointment of the professional staff and the granting of clinical privileges and shall be responsible for the professional conduct of these persons.

(d) The governing authority shall establish written policies and procedures to assure billing and collection practices in accordance with G.S. 131E-91. These policies and procedures shall include:

(1) a financial assistance policy as defined in G.S. 131E-214.14(b)(3);

(2) how a patient may obtain an estimate of the charges for the statewide 20 most common outpatient imaging procedures and 20 most common outpatient surgical procedures based on the primary Current Procedure Terminology Code (CPT). The policy shall require that the information be provided to the patient in writing, either electronically or by mail, within three business days;

(3) how a patient or patient's representative may dispute a bill;

(4) issuance of a refund within 45 days of the patient receiving notice of the overpayment when a patient has overpaid the amount due to the facility;

(5) providing written notification to the patient or patient's representative, 30 days prior to submitting a delinquent bill to a collections agency;

(6) providing the patient or patient's representative with the facility's charity care and financial assistance policies, if the facility is required to file a Schedule H, federal form 990;

(7) the requirement that a collections agency, entity, or other assignee obtain written consent from the facility prior to initiating litigation against the patient or patient's representative;

(8) a policy for handling debts arising from the provision of care by the ambulatory surgical facility involving the doctrine of necessaries, in accordance with G.S. 131E-91(d)(5); and

(9) a policy for handling debts arising from the provision of care by the ambulatory surgical facility to a minor, in accordance with G.S. 131E-91(d)(6).

History Note: Authority G.S. 131E-91; 131E-147.1; 131E-149; 131E-214.13(f); 131E-214.14;
Eff. October 14, 1978;
Amended Eff. November 1, 1989; November 1, 1985; December 24, 1979;
Temporary Amendment Eff. May 1, 2014;
Amended Eff. November 1, 2014;
Readopted Eff. January 1, 2021.

10A NCAC 13C .0302 CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

(a) The governing authority shall appoint a qualified person as chief executive officer of the facility to represent the governing authority and shall define his authority and duties in writing. He shall be responsible for the management of the facility, implementation of the policies of the governing authority and authorized and empowered to carry out the provisions of these regulations.
(b) The chief executive officer shall designate, in writing, a qualified person to act in his behalf during his absence. In the absence of the chief executive officer, the person on the grounds of the facility who is designated by the chief executive officer to be in charge of the facility shall have reasonable access to all areas in the facility related to patient care and to the operation of the physical plant.
(c) When there is a planned change in ownership or in the chief executive officer, the governing authority of the facility shall notify the Department.

History Note: *Authority G.S. 131E-149;*
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .0303 ADMINISTRATIVE RECORDS

(a) The following essential documents and references shall be on file in the administrative office of the facility:

(1) appropriate documents evidencing control and ownerships, such as deeds, leases, or corporation or partnership papers;
(2) bylaws of policies and procedures of the governing authority;
(3) minutes of the governing authority meetings if applicable;
(4) minutes of the facility's professional and administrative staff meetings;
(5) a current copy of these regulations;
(6) reports of inspections, reviews, and corrective actions taken related to licensure; and
(7) contracts and agreements related to licensure to which the facility is a party.

(b) All operating licenses, permits and certificates shall be appropriately displayed on the licensed premises.

History Note: *Authority G.S. 131E-149;*
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .0304 SURGICAL PROCEDURES PERFORMED

A current listing of all types of surgical procedures offered by the facility shall be available.

History Note: *Authority G.S. 131E-149;*
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .0305 PERSONNEL

(a) Personnel Records

(1) A record of each employee shall be maintained which includes the following:
    (A) employee's identification;
    (B) resume of education and work experience;
    (C) verification of valid license (if required), education, training, and prior employment experience; and
    (D) verification of references.
(2) Personnel records shall be confidential.
(3) Notwithstanding the requirement found in Subparagraph (a)(2) of this Rule, representatives of the Department conducting an inspection of the facility shall have the right to inspect personnel records.

(b) Job Descriptions

(1) Every position shall have a written description which adequately describes the duties of the position.

(2) Each job description shall include position title, authority, specific responsibilities and minimum qualifications. Qualifications shall include education, training, experience, special abilities and license or certification required.

(3) Job descriptions shall be reviewed annually, kept current and given to each employee when assigned to the position and whenever the job description is changed.

(c) Orientation shall be provided to familiarize each new employee with the facility, its policies, and job responsibilities.

(d) All persons having direct responsibility for patient care shall be at least 18 years of age. All other employees working in the facility shall be not less than 16 years of age.

(e) The governing authority shall be responsible for insuring health standards for employees which are consistent with recognized professional practices for the prevention and transmission of communicable diseases.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Amended Eff. November 1, 1989; December 24, 1979;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .0306 QUALITY ASSURANCE

(a) The governing authority shall establish a quality assurance program for the purpose of providing standards of care for the facility. The program shall include the establishment of a committee which shall evaluate:

(1) appropriateness and necessity of surgical procedures performed, and

(2) compliance with facility procedure and policies.

The committee shall determine corrective action if indicated.

(b) The committee shall consist of at least one physician or dentist (who is not an owner), the chief executive officer (or his designee), and other health professionals as indicated. There shall be at least one meeting of the committee quarterly.

(c) The functions of the committee shall include development of policies for selection of patients, review of credentials for staff privileges, peer review, tissue review, establishment of infection control procedures, and approval of additional surgical procedures to be performed in the facility.

(d) Records shall be kept of the activities of the committee. These records shall include as a minimum:

(1) reports made to the governing authority;

(2) minutes of committee meetings including date, time, persons attending, description and results of cases reviewed, and recommendations made by the committee; and

(3) information on any corrective action taken.

(e) Appropriate orientation, training or education programs shall be conducted as necessary to correct deficiencies which are uncovered as a result of the quality assurance program.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

SECTION .0400 - MEDICAL AND SURGICAL SERVICES

10A NCAC 13C .0401 MEDICAL SERVICES

(a) All patients admitted to the facility shall be under the direct care of a physician or dentist.

(b) The facility shall have available an anesthetist and he or she shall be available to administer regional or general anesthesia.

(c) Any patient undergoing general or regional anesthesia shall, prior to surgery, have a history and physical examination, relative to the intended procedure, performed by a licensed physician or a dentist who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the American Dental Association. Results of the examination and the preoperative diagnosis shall be recorded in the patient's chart prior to surgery.

(d) The attending physician and dentist, prior to surgery, shall obtain written, informed consent of the patient or legal guardian for surgery and shall record this in the patient's medical record.

(e) The facility shall have the capability of obtaining blood and blood products to meet emergency situations.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Amended Eff. November 1, 1985;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .0402 SURGICAL SERVICES

(a) The governing authority shall delineate surgical privileges for each physician and dentist performing surgery in accordance with criteria which it has established provided, however, that no physician or dentist may be given privileges to perform surgical procedures for which he or she does not have privileges to perform at the hospital with which the facility has a transfer agreement as provided in Paragraph (a) in Rule .0403 of this Section.
(b) A roster of medical personnel having surgical and anesthesia privileges at the facility specifying the privileges and limitations of each, shall be readily obtainable by the person in charge of the surgical suite.
(c) The administrator or his designee shall maintain a chronological register of all surgical procedures performed. This shall include type of procedure performed, type of anesthesia used, personnel participating, post operative diagnosis and any unusual or untoward occurrence.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Amended Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .0403 EMERGENCY CASES

(a) Each facility shall have a written plan for the transfer of emergency cases to a nearby hospital when hospitalization becomes necessary.
(b) There shall be procedures, personnel and suitable equipment to handle medical emergencies which may arise in connection with services provided by the facility.
(c) There shall be a written agreement between the facility and a nearby hospital to facilitate the transfer of patients who are in need of emergency care. A facility which has documentation of its efforts to establish such a transfer agreement with a hospital which provides emergency services and has been unable to secure such an agreement shall be considered to be in compliance with this Rule.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

SECTION .0500 - ANESTHESIA SERVICES

10A NCAC 13C .0501 PROVIDING ANESTHESIA SERVICES

Only a physician, dentist, qualified anesthetist, or qualified anesthesiologist as defined in Rule .0103 of this Subchapter, shall administer anesthetic agents. Podiatrists shall administer only local anesthesia. The governing authority shall establish written policies and procedures concerning the provision of anesthesia services, including the designation of those persons authorized to administer anesthetics in accordance with State law.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Readopted Eff. January 1, 2021.

10A NCAC 13C .0502 EQUIPMENT

All equipment for the administration of anesthetics shall be readily available, kept clean or sterile, and maintained in good working condition.

History Note: Authority G.S. 131E-149;

Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .0503 POST ANESTHESIA NOTE
Patient's anesthesiologist or anesthetist shall write a post anesthetic follow-up note prior to the patient's discharge. The note shall include the general condition of the patient and any instructions to the patient pertaining to his care and protection.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .0504 REQUIREMENT OF PERSON TRAINED IN CPR
A person with training and experience in cardio-pulmonary resuscitation shall be on the premises of the facility until all surgical patients are discharged.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

SECTION .0600 - PATHOLOGY SERVICES

10A NCAC 13C .0601 PROVISION FOR LABORATORY TESTS
(a) Each facility shall have the capability of providing or obtaining laboratory tests required in connection with the surgery to be performed.
(b) The governing authority shall establish written policies requiring examination by a pathologist of all surgical specimens except for those types of specimens which the governing authority has determined do not require examination.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .0602 DISPOSAL OF WASTE
Methods for the disposal of pathological waste, contaminated dressings and other similar material shall meet the approval of governing local and state authorities.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

SECTION .0700 - RADIOLOGY SERVICES

10A NCAC 13C .0701 PROVISION FOR RADIOLOGY SERVICES
Each facility shall have the capability of providing or obtaining diagnostic radiology services in connection with the surgery to be performed.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .0702 REGULATIONS FOR PERFORMED SERVICES
Radiation protection shall be provided in accordance with the rules adopted by the Radiation Protection Commission found in 10A NCAC 15. Records shall be kept of annual checks and calibration of all ionizing radiation therapy equipment used in the facility.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017;
Amended Eff. January 1, 2021.

SECTION .0800 - PHARMACEUTICAL SERVICES

10A NCAC 13C .0801 DRUG DISPENSING
The governing authority, with the advice of a registered pharmacist, shall assure that there are appropriate methods, procedures and controls for obtaining, dispensing, and administering drugs and biologicals.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .0802 REGULATIONS FOR DISPENSING
When the facility maintains its own pharmaceutical services, it shall comply with applicable regulations adopted by the North Carolina Board of Pharmacy pursuant to General Statute 90-85.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017;
Amended Eff. September 1, 2019.

SECTION .0900 - NURSING SERVICES

10A NCAC 13C .0901 NURSING ADMINISTRATION
(a) The facility shall have an organized nursing Department under the supervision of a director of nursing who is currently licensed as a registered nurse and who has responsibility and accountability for all nursing services.
(b) The director of nursing shall be responsible and accountable to the chief executive officer for:
(1) provision of nursing services to patients;
(2) developing a nursing policy and procedure manual and written job descriptions for nursing personnel.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Amended Eff. December 24, 1979;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .0902 NURSING PERSONNEL
(a) Licensed and ancillary nursing personnel shall be on duty to assure that staffing levels meet the nursing needs of patients in the facility and their individual nursing care needs.
(b) At least one registered nurse shall be in the facility during the hours of operation. Nursing personnel shall be assigned to duties consistent with their training and experience.

History Note: Authority G.S. 131E-149;

Eff. October 14, 1978;
Readopted Eff. January 1, 2021.

SECTION .1000 - MEDICAL RECORDS SERVICES

10A NCAC 13C .1001 MEDICAL RECORD SYSTEM

The facility shall maintain a medical record system designed to provide readily available information on each patient. The medical record system shall be under the supervision of a designated qualified person.

History Note: *Authority G.S. 131E-149;*
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .1002 INDIVIDUAL PATIENT RECORDS

(a) Each patient's medical record shall be maintained in accordance with professional standards and shall include at least the following information:

(1) patient's identification, including name, address, date of birth, next of kin and a patient number;
(2) admitting diagnosis;
(3) preoperative history and physical examination pertaining to the procedure to be performed;
(4) anesthesia report;
(5) surgeon's operative report;
(6) anesthesiologist's or anesthetist's report if applicable;
(7) pertinent laboratory, pathology and X-ray reports;
(8) postoperative orders and follow-up care;
(9) discharge summary, including discharge diagnosis;
(10) record of informed consent; and
(11) physician's, dentist's, and nurse's progress notes.

(b) The administrator shall be responsible for safeguarding information on the medical record against loss, tampering, or use by unauthorized persons.
(c) Medical records shall be the property of the facility and shall not be moved from the premises wherein they are filed except by subpoena or court order.
(d) For licensing purposes the length of time that medical records are to be retained is dependent upon the need for their use in continuing patient care and for legal, research, or educational purposes. This length of time shall not be less than 20 years.
(e) Should a facility cease operation, there shall be an arrangement for preservation of records to insure compliance with these regulations. The Department shall be notified, in writing, concerning the arrangements.

History Note: *Authority G.S. 131E-149;*
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

SECTION .1100 - SURGICAL FACILITIES AND EQUIPMENT

10A NCAC 13C .1101 OPERATING SUITE

(a) Each operating suite shall be adequately equipped for the types of procedures to be performed.
(b) Each recovery area shall be adequately equipped for the proper care of post anesthesia recovery of surgical patients.
(c) The following equipment shall be available in the operating suite and recovery area:

(1) cardio-pulmonary resuscitation drugs and intubation equipment,
(2) cardiac monitor,
(3) resuscitator including oxygen and suction equipment,
(4) suitable surgical instruments customarily available for the planned surgical procedure,
(5) defibrillator, and
(6) tracheostomy set.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .1102 CARE OF OPERATING SUITE

(a) Dry sweeping and dusting shall be prohibited in treatment areas.
(b) Adequate and conveniently located spaces shall be provided for the storage of janitorial supplies and equipment.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

SECTION .1200 - FUNCTIONAL SAFETY

10A NCAC 13C .1201 GENERAL

(a) The governing authority shall develop written policies and procedures designed to enhance safety within the facility and on its grounds and minimize hazards to patients, staff and visitors.
(b) The policies and procedures shall include establishment of the following:

- (1) safety rules and practices pertaining to personnel, equipment, gases, liquids, drugs;
- (2) provisions for reporting and the investigation of accidental events regarding patients, visitors and personnel (incidents) and corrective action taken;
- (3) provision for dissemination of safety-related information to employees and users of the facility; and
- (4) provision for syringe and needle storage, handling and disposal.

(c) Smoking shall be permitted only in designated areas which shall not include patient care and treatment areas.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Amended Eff. December 24, 1979;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .1202 PREVENTIVE MAINTENANCE

A schedule of preventive maintenance shall be developed for all of the medical and surgical equipment in the facility to assure satisfactory operation when needed.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Amended Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

SECTION .1300 - CONTROL AND SANITATION

10A NCAC 13C .1301 GENERAL

The governing authority shall employ procedures to minimize sources and transmission of infections. Professionally recognized surveillance methods shall be used. The governing authority shall provide space, equipment, and personnel to assure safe and aseptic treatment and protection of all patients and personnel against cross-infection.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Amended Eff. November 1, 1989;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .1302 STERILIZATION PROCEDURES

(a) Policies and procedures shall be established in writing for storage, maintenance and distribution of sterile supplies and equipment.
(b) Sterile supplies and equipment shall not be mixed with unsterile supplies, and shall be stored in dust proof and moisture free units. They shall be properly labeled.
(c) Sterilizing equipment shall be available and of the necessary type and capacity to sterilize instruments and operating room materials, as well as laboratory equipment and supplies. The sterilizing equipment shall have design control and safety features intact. The accuracy of instrumentation and equipment shall be checked quarterly by any professionally recognized method and periodic calibration and preventive maintenance shall be provided as necessary, and a log maintained.
(d) The date of expiration shall be marked on all supplies sterilized in the facility.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Amended Eff. November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .1303 HOUSEKEEPING

Operating rooms shall be appropriately cleaned in accordance with established written procedures after each operation. Recovery rooms shall be maintained in a clean condition.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .1304 LINEN AND LAUNDRY

(a) An adequate supply of clean linen or disposable materials shall be maintained.
(b) Provisions for proper laundering of linen and washable goods shall be made. Soiled and clean linen shall be handled and stored separately.
(c) A sufficient supply of cloth or disposable towels shall be available so that a fresh towel can be used after each handwashing. Towels shall not be shared.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

10A NCAC 13C .1305 SANITATION

(a) All parts of the facility, the premises and equipment shall be kept clean and free of insects, rodents, litter and rubbish.
(b) All garbage and waste shall be collected, stored and disposed of in a manner designed to prevent the transmission of disease. Containers shall be washed and sanitized before being returned to work areas. Disposable type containers shall not be reused.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

SECTION .1400 - PHYSICAL PLANT CONSTRUCTION

10A NCAC 13C .1401 DEFINITIONS

In addition to the definitions set forth in G.S. 131E-146, the following definitions shall apply in Section .1400 of this Subchapter:

(1) "Addition" means an extension or increase in floor area or height of a building.

(2) "Alteration" means any construction or renovation to an existing building other than construction of an addition.

(3) "Construction documents" means final building plans and specifications for the construction of a facility that a governing body submits to the Construction Section for approval as specified in Rule .0202 of this Subchapter.

(4) "Construction Section" means the Construction Section of the Division of Health Service Regulation.

(5) "Division" means the Division of Health Service Regulation of the North Carolina Department of Health and Human Services.

(6) "Facility" means an ambulatory surgical facility as defined in G.S. 131E-146.

(7) "FGI Guidelines" means the Guidelines for Design and Construction of Outpatient Facilities that is incorporated by reference in Rule .1402 of this Section.

History Note: Authority G.S. 131E-145; 131E-146; 131E-149;
Eff. October 14, 1978;
Amended Eff. December 24, 1979;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017;
Amended Eff. January 1, 2020.

10A NCAC 13C .1402 LIST OF REFERENCED GUIDELINES, CODES, STANDARDS, AND REGULATION

(a) The FGI Guidelines are incorporated herein by reference, including all subsequent amendments and editions; however, the following chapters of the FGI Guidelines shall not be incorporated herein by reference:

(1) Chapter 2.3;
(2) Chapter 2.4;
(3) Chapter 2.5;
(4) Chapter 2.6;
(5) Chapter 2.8;
(6) Chapter 2.10;
(7) Chapter 2.11;
(8) Chapter 2.12;
(9) Chapter 2.13; and
(10) Chapter 2.14.

Copies of the FGI Guidelines may be purchased from the Facility Guidelines Institute online at https://www.fgiguidelines.org/guidelines-main/purchase/ at a cost of two hundred dollars ($200.00) or accessed electronically free of charge at https://www.fgiguidelines.org/guidelines-main/.

(b) For the purposes of the rules of this Section, the following codes, standards, and regulation are incorporated herein by reference including subsequent amendments and editions. Copies of these codes, standards, and regulation may be obtained or accessed from the online addresses listed:

(1) the North Carolina State Building Codes with copies that may be purchased from the International Code Council online at https://shop.iccsafe.org/ at a cost of six hundred sixty-six dollars ($666.00) or accessed electronically free of charge at https://shop.iccsafe.org/state-and-local-codes/north-carolina.html;

(2) the following National Fire Protection Association standards, codes, and guidelines with copies of these standards, codes, and guidelines that may be accessed electronically free of charge at https://www.nfpa.org/Codes-and-Standards/All-Codes-and-Standards/List-of-Codes-and-Standards or may be purchased online at https://catalog.nfpa.org/Codes-and-Standards-C3322.aspx for the costs listed:

(A) NFPA 22, Standard for Water Tanks for Private Fire Protection for a cost of fifty-four dollars ($54.00);

(B) NFPA 53, Recommended Practice on Materials, Equipment, and Systems Used in Oxygen-Enriched Atmospheres for a cost of fifty-three dollars ($53.00);
(C) NFPA 59A, Standard for the Production, Storage, and Handling of Liquefied Natural Gas for a cost of fifty-four dollars ($54.00);
(D) NFPA 99, Health Care Facilities Code for a cost of seventy-seven dollars ($77.00);
(E) NFPA 101, Life Safety Code for a cost of one hundred and five dollars and fifty cents ($105.50);
(F) NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials for a cost of forty-two dollars ($42.00);
(G) NFPA 407, Standard for Aircraft Fuel Servicing for a cost of forty-nine dollars ($49.00);
(H) NFPA 705, Recommended Practice for a Field Flame Test for Textiles and Films for a cost of forty-two dollars ($42.00);
(I) NFPA 780, Standard for the Installation of Lightning Protection Systems for a cost of sixty-three dollars and fifty cents ($63.50);
(J) NFPA 801, Standard for Fire Protection for Facilities Handling Radioactive Materials for a cost of forty-nine dollars ($49.00); and
(K) Fire Protection Guide to Hazardous Materials for a cost of one hundred and thirty-five dollars and twenty-five cents ($135.25).

(3) 42 CFR Part 416.54 Condition of participation: Emergency preparedness with copies of this regulation that may be accessed free of charge at https://www.gpo.gov/fdsys/pkg/CFR-2017-title42-vol5/xml/CFR-2017-title42-vol5-sec482-15.xml or purchased online at https://bookstore.gpo.gov/products/cfr-title-42-pt-482-end-code-federal-regulationspaper-201-7 for a cost of seventy-seven dollars ($77.00).

History Note: *Authority G.S. 131E-149;*
Eff. October 14, 1978;
Amended Eff. December 24, 1979;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017;
Amended Eff. January 1, 2020.

10A NCAC 13C .1403 GENERAL AND EMERGENCY PREPAREDNESS

(a) A new facility or any addition or alterations to an existing facility whose construction documents were approved by the Construction Section on or after July 1, 2020 shall meet the requirements set forth in:
(1) the rules of this Section; and
(2) the FGI Guidelines.

(b) An existing facility whose construction documents were approved by the Construction Section prior to July 1, 2020 shall meet those standards established in the rules of this Section that were in effect at the time the construction documents were approved by the Construction Section. Previous versions of the rules of this Section can be accessed online at https://info.ncdhhs.gov/dhsr/const/index.html.

(c) The facility shall develop and maintain an emergency preparedness program as required by 42 CFR Part 416.54 Condition of Participation: Emergency Preparedness. The emergency preparedness program shall be developed with input from the local fire department and local emergency management agency. Documentation required to be maintained by 42 CFR Part 416.54 shall be maintained at the facility for at least three years and shall be made available to the Division during an inspection upon request.

(d) Any existing building converted from another use to a new facility shall meet the requirements of Paragraph (a) of this Rule.

History Note: *Authority G.S. 131E-149; 42 CFR Part 416.54;*
Eff. October 14, 1978;
Amended Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017;
Amended Eff. January 1, 2020.

10A NCAC 13C .1404 EQUIVALENCY AND CONFLICTS WITH REQUIREMENTS

(a) The Division may grant an equivalency to allow an alternate design or functional variation from the requirements in the rules contained in this Section. The equivalency may be granted by the Division if a governing body submits a written equivalency request to the Division that indicates the following:

(1) the rule citation and the rule requirement that will not be met;
(2) the justification for the equivalency;
(3) how the proposed equivalency meets the intent of the corresponding rule requirement; and
(4) a statement by the governing body that the equivalency request will not reduce the safety and operational effectiveness of the facility design and layout.

The governing body shall maintain a copy of the approved equivalence issued by the Division.

(b) If the rules, codes, or standards contained in this Subchapter conflict, the most restrictive requirement shall apply.

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Amended Eff. November 1, 1989; December 24, 1979;
Readopted Eff. January 1, 2020.

10A NCAC 13C .1405 MECHANICAL REQUIREMENTS
10A NCAC 13C .1406 PLUMBING AND OTHER PIPING SYSTEMS
10A NCAC 13C .1407 ELECTRICAL REQUIREMENTS

History Note: Authority G.S. 131E-149;
Eff. October 14, 1978;
Amended Eff. April 1, 2003; December 24, 1979;
Repealed Eff. January 1, 2020.

10A NCAC 13C .1408 GENERAL
10A NCAC 13C .1409 LIST OF REFERENCED CODES AND STANDARDS

History Note: Authority G.S. 131E-149;
Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017;
Repealed Eff. January 1, 2020.

10A NCAC 13C .1410 APPLICATION OF PHYSICAL PLANT REQUIREMENTS

History Note: Authority G.S. 131E-149;
Eff. April 1, 2003;
Repealed Eff. January 1, 2020.

10A NCAC 13C .1411 ACCESS AND SAFETY

Projects involving replacement of, alterations of, and additions to existing licensed facilities shall be planned and phased so that construction will minimize disruptions of facility operations. Facility access, exit ways, safety provisions, and building and life safety systems shall be maintained so that the health and safety of the occupants will not be jeopardized during construction. Additional safety and operating measures shall be planned, documented, and executed to compensate for hazards related to construction or renovation activities to maintain an equivalent degree of health, safety, and operational effectiveness to that required by rules, standards, and codes for a facility not under construction or renovation.

History Note: Authority G.S. 131E-149;
Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 23, 2017.

SUBCHAPTER 13D – RULES FOR THE LICENSING OF NURSING HOMES

SECTION .0100 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .0100 RESERVED FOR FUTURE CODIFICATION

SECTION .0200 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .0200 RESERVED FOR FUTURE CODIFICATION

SECTION .0300 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .0300 RESERVED FOR FUTURE CODIFICATION

SECTION .0400 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .0400 RESERVED FOR FUTURE CODIFICATION

SECTION .0500 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .0500 RESERVED FOR FUTURE CODIFICATION

SECTION .0600 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .0600 RESERVED FOR FUTURE CODIFICATION

SECTION .0700 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .0700 RESERVED FOR FUTURE CODIFICATION

SECTION .0800 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .0800 RESERVED FOR FUTURE CODIFICATION

SECTION .0900 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .0900 RESERVED FOR FUTURE CODIFICATION

SECTION .1000 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .1000 RESERVED FOR FUTURE CODIFICATION

SECTION .1100 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .1100 RESERVED FOR FUTURE CODIFICATION

SECTION .1200 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .1200 RESERVED FOR FUTURE CODIFICATION

SECTION .1300 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .1300 RESERVED FOR FUTURE CODIFICATION

SECTION .1400 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .1400 RESERVED FOR FUTURE CODIFICATION

SECTION .1500 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .1500 RESERVED FOR FUTURE CODIFICATION

SECTION .1600 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .1600 RESERVED FOR FUTURE CODIFICATION

SECTION .1700 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .1700 RESERVED FOR FUTURE CODIFICATION

SECTION .1800 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .1800 RESERVED FOR FUTURE CODIFICATION

SECTION .1900 - RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .1900 RESERVED FOR FUTURE CODIFICATION

SECTION .2000 – GENERAL INFORMATION

10A NCAC 13D .2001 DEFINITIONS

In addition to the definitions set forth in G.S. 131E-101, the following definitions shall apply throughout this Subchapter:

(1) "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish.

(2) "Accident" means an unplanned event resulting in the injury or wounding of a patient or other individual.

(3) "Addition" means an extension or increase in floor area or height of a building.

(4) "Administrator" as defined in G.S. 90-276(4).

(5) "Alteration" means any construction or renovation to an existing structure other than repair, maintenance, or addition.

(6) "Brain injury long term care" means an interdisciplinary, intensive maintenance program for patients who have incurred brain damage caused by external physical trauma and who have completed a primary course of rehabilitative treatment and have reached a point of no gain or progress for more than three consecutive months. Brain injury long term care is provided through a medically supervised interdisciplinary process and is directed toward maintaining the individual at the optimal level of physical, cognitive, and behavioral functions.

(7) "Capacity" means the maximum number of patient or resident beds for which the facility is licensed to maintain at any given time.

(8) "Combination facility" means a combination home as defined in G.S. 131E-101.

(9) "Comprehensive, inpatient rehabilitation program" means a program for the treatment of persons with functional limitations or chronic disabling conditions who have the potential to achieve a significant improvement in activities of daily living, including bathing, dressing, grooming, transferring, eating, and using speech, language, or other communication systems. A comprehensive, inpatient rehabilitation program utilizes a coordinated and integrated, interdisciplinary approach, directed by a physician, to assess patient needs and to provide treatment and evaluation of physical, psychosocial, and cognitive deficits.

(10) "Department" means the North Carolina Department of Health and Human Services.

(11) "Director of nursing" means a registered nurse who has authority and responsibility for all nursing services and nursing care.

(12) "Discharge" means a physical relocation of a patient to another health care setting; the discharge of a patient to his or her home; or the relocation of a patient from a nursing bed to an adult care home bed, or from an adult care home bed to a nursing bed.
(13) "Existing facility" means a facility currently licensed and built prior to the effective date of this Rule.
(14) "Facility" means a nursing facility or combination facility as defined in this Rule.
(15) "Incident" means any accident, event, or occurrence that is unplanned, or unusual, and has caused harm to a patient, or has the potential for harm.
(16) "Inpatient rehabilitation facility or unit" means a free-standing facility or a unit (unit pertains to contiguous dedicated beds and spaces) within an existing licensed health service facility approved in accordance with G.S. 131E, Article 9 to establish inpatient, rehabilitation beds and to provide a comprehensive, inpatient rehabilitation program.
(17) "Interdisciplinary" means an integrated process involving representatives from disciplines of the health care team.
(18) "Licensee" means the person, firm, partnership, association, corporation, or organization to whom a license to operate the facility has been issued. The licensee is the legal entity that is responsible for the operation of the business.
(19) "Medication error rate" means the measure of discrepancies between medication that was ordered for a patient by the health care provider and medication that is administered to the patient. The medication error rate is calculated by dividing the number of errors observed by the surveyor by the opportunities for error, multiplied times 100.
(20) "Misappropriation of property" means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a patient's belongings or money without the patient's consent.
(21) "Neglect" means a failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.
(22) "New facility" means a facility for which an initial license is sought, a proposed addition to an existing facility, or a proposed remodeled portion of an existing facility that will be built according to construction documents and specifications approved by the Department for compliance with the standards established in Sections .3100, .3200, and .3400 of this Subchapter.
(23) "Nurse Aide" means a person who is listed on the N.C. Nurse Aide Registry and provides nursing or nursing-related services to patients in a nursing home. A nurse aide is not a licensed health professional. Nursing homes that participate in Medicare or Medicaid shall comply with 42 CFR 483.35, which is incorporated by reference, including subsequent amendments. The Code of Federal Regulations may be accessed at https://www.ecfr.gov.
(24) "Nursing facility" means a nursing home as defined in G.S. 131E-101.
(25) "Patient" means any person admitted for nursing care.
(26) "Remodeling" means alterations, renovations, rehabilitation work, repairs to structural systems, and replacement of building systems at a nursing or combination facility.
(27) "Repair" means reconstruction or renewal of any part of an existing building for the purpose of its maintenance.
(28) "Resident" means any person admitted for care to an adult care home part of a combination facility.
(29) "Respite care" means services provided for a patient on a temporary basis, not to exceed 30 days.
(30) "Surveyor" means a representative of the Department who inspects nursing facilities and combination facilities to determine compliance with rules, laws, and regulations as set forth in G.S. 131E-117; Subchapters 13D and 13F of this Chapter; and 42 CFR Part 483, Requirements for States and Long Term Care Facilities.
(31) "Violation" means a failure to comply with rules, laws, and regulations as set forth in G.S. 131E-117 and 131D–21; Subchapters 13D and 13F of this Chapter; or 42 CFR Part 483, Requirements for States and Long Term Care Facilities, that relates to a patient's or resident's health, safety, or welfare, or that creates a risk that death, or physical harm may occur.

History Note: *Authority G.S. 131E-104;*
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Readopted Eff. July 1, 2016;

Amended Eff. October 1, 2021; January 1, 2021.

SECTION .2100 - LICENSURE

10A NCAC 13D .2101 APPLICATION REQUIREMENTS

(a) A legal entity shall submit an application for licensure for a new facility to the Nursing Home Licensure and Certification Section of the Division of Health Service Regulation at least 30 days prior to a license being issued or patients admitted.

(b) The application shall contain the following:

(1) legal identity of applicant (licensee) and mailing address;
(2) name or names under which the facility is presented to the public;
(3) location and mailing address of facility;
(4) ownership disclosure;
(5) bed complement;
(6) magnitude and scope of services offered;
(7) name and current license number of the administrator;
(8) name and current license number of the director of nursing; and
(9) name and current license number of the medical director.

History Note: Authority G.S. 131E-104; 131E-102;
Eff. January 1, 1996;
Amended Eff. July 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2102 ISSUANCE OF LICENSE

(a) Only one license shall be issued to each facility. The Department shall issue a license to the licensee of the facility following review of operational policies and procedures and verification of compliance with applicable laws and rules.

(b) Licenses are not transferable.

(c) The bed capacity and services provided in a facility shall be in compliance with G.S. 131E, Article 9 regarding Certificate of Need.

(d) The license shall be posted in a prominent location, accessible to public view, within the licensed premises.

History Note: Authority G.S. 131E-104;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2103 LENGTH OF LICENSURE

Licenses shall remain in effect up to 12 months, unless any of the following occurs:

(1) Department imposes an administrative sanction which specifies license expiration;
(2) closure;
(3) change of ownership;
(4) change of site;
(5) change in bed complement; or
(6) failure to comply with Rule .2104 of this Section.

History Note: Authority G.S. 131E-104;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2104 REQUIREMENTS FOR LICENSURE RENEWAL OR CHANGES

(a) The Department shall renew the facility's license at the end of each calendar year, if the following occur:

(1) The licensee maintains and submits to the Department, at least 30 days prior to the licensure expiration date, statistical data for the State's medical facilities plan and review for certificate of need determination. The Department shall provide forms annually to the facility for this purpose.
(2) The facility is in conformance with G.S. 131E-102(c).
(3) The combination facility shall specify on the annual license renewal application with which rules for the adult care home beds it plans to comply for the upcoming calendar year. The rule selection shall be effective for the duration of the renewed licensed year. The facility may choose one of the following:
(A) nursing home licensure rules under this Subchapter;
(B) adult care home licensure rules under 10A NCAC 13F; or
(C) a combination of nursing home and adult care home licensure rules. The facility shall identify in writing the specific rule governing compliance with the adult care home rules and shall identify in writing the specific requirements governing compliance with the nursing home rules.

(b) The facility shall notify the Nursing Home Licensure and Certification Section of the Division of Health Service Regulation in writing and make changes in the licensure application at least 30 days prior to the occurrence of the following:
(1) a change in the name or names under which the facility is presented to the public;
(2) a change in the legal identity (licensee) which has ownership responsibility and liability (such information shall be submitted by the proposed new owner);
(3) a change in the licensed bed capacity; or
(4) a change in the location of the facility.

The Department shall issue a new license following notification and verification of data submitted.

(c) The facility shall notify the Nursing Home Licensure and Certification Section of the Division of Health Service Regulation within one working day following the occurrence of:
(1) change in administration;
(2) change in the director of nursing;
(3) change in facility mailing address or telephone number;
(4) changes in magnitude or scope of services; or
(5) emergencies or situations requiring relocation of patients to a temporary location away from the facility.

History Note: Authority G.S. 131E-104;
Eff. January 1, 1996;
Amended Eff. September 1, 2006;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2105 TEMPORARY CHANGE IN BED CAPACITY

(a) A continuing care retirement community, having an agreement to care for all residents regardless of level of care needs, may temporarily increase bed capacity by 10 percent or 10 beds, whichever is less, over the licensed bed capacity for a period up to 60 days following notification to and approval by the Division of Health Service Regulation.

(b) In an emergency situation, such as a natural disaster, a facility may exceed its licensed capacity as determined by its disaster plan and as authorized by the Division of Health Service Regulation. Emergency authorizations shall not exceed 60 days.

(c) The Division shall authorize, in writing, a temporary increase in licensed beds in accordance with Paragraphs (a) and (b) of this Rule, if it is determined that:
(1) the increase is not associated with a capital expenditure; and
(2) the increase would not jeopardize the health, safety and welfare of the patients.

History Note: Authority G.S. 131E-104; 131E-112;
Eff. January 1, 1996;
Amended Eff. March 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2106 DENIAL, AMENDMENT, OR REVOCATION OF LICENSE

(a) The Department shall deny any licensure application upon becoming aware that the applicant is not in compliance with G.S. 131E, Article 9 and the rules adopted under that law.

(b) The Department may amend a license by reducing it from a full license to a provisional license whenever the Department finds that:

(1) the licensee has substantially failed to comply with the provisions of G.S. 131E, Article 6 and the rules promulgated under that article; and

(2) there is continued non-compliance after the third revisit.

(c) The Department shall give the licensee written notice of the amendment to the license. This notice shall be given personally or by certified mail and shall set forth:

(1) the length of the provisional license;

(2) a reference to the statement of deficiencies that contains the facts;

(3) the statutes or rules alleged to be violated; and

(4) notice of the facility's right to a contested case hearing on the amendment of the license.

(d) The provisional license shall be effective as specified in the notice and shall be posted in a location within the facility, accessible to public view, in lieu of the full license. The provisional license shall remain in effect until:

(1) the Department restores the licensee to full licensure status; or

(2) the Department revokes the licensee's license.

(e) The Department may revoke a license whenever:

(1) The Department finds that:

(A) the licensee has substantially failed to comply with the provisions of G.S. 131E, Article 6 and the rules promulgated under that article; and

(B) there continues to be non-compliance at the third revisit; or

(2) The Department finds that there has been any failure to comply with the provisions of G.S. 131E, Article 6 and the rules promulgated under that article that endanger the health, safety or welfare of the patients in the facility.

(f) The issuance of a provisional license is not a procedural prerequisite to the revocation of a license pursuant to Paragraph (e) of this Rule.

(g) The Department may, in accordance with G.S. 131E-232, petition to have a temporary manager appointed to operate a facility.

History Note: Authority G.S. 131E-104;
Eff. January 1, 1996;
Amended Eff. January 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2107 SUSPENSION OF ADMISSIONS

(a) The Department may suspend the admission of new patients to a facility when warranted under the provisions of G.S. 131E-109(c).

(b) The Department shall notify the facility personally or by certified mail of the decision to suspend admissions. Such notice shall include:

(1) a reference to the statement of deficiencies that contains the facts;

(2) citation of statutes and rules alleged to be violated; and

(3) notice of the facility's right to a contested case hearing on the suspension.

(c) The suspension is effective on the date specified in the notice of suspension. The suspension shall remain effective until the facility demonstrates to the Department that conditions are no longer detrimental to the health and safety of the patients.

(d) The facility shall not admit new patients during the effective period of the suspension.

(e) Patients requiring hospitalization during the period of suspension of admissions shall be readmitted after hospitalization or on return from temporary care to the facility based on the availability of a bed and the ability of the facility to provide necessary care. Upon return from the hospital, the requirements of G.S. 131E-130 apply.

History Note: Authority G.S. 131E-104;
Eff. January 1, 1996;

Amended Eff. January 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2108 PROCEDURE FOR APPEAL
(a) The facility may appeal any decision of the Department to deny, revoke or alter a license or any decision to suspend admissions by making such an appeal in accordance with G.S. 150B and 10A NCAC 01.
(b) A decision to issue a provisional license is stayed during the pendency of an administrative appeal and the licensee may continue to display full license during the appeal.

History Note: *Authority G.S. 131E-104;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2109 INSPECTIONS
(a) The facility shall allow inspection by an authorized representative of the Department at any time.
(b) At the time of inspection, any authorized representative of the Department shall make his or her presence known to the administrator or other person in charge who shall cooperate with the representative and facilitate the inspection.
(c) Inspections of medical records will be carried out in accordance with G.S. 131E-105.
(d) The administrator shall provide and make available to representatives of the Department financial and statistical records required to verify compliance with all rules contained in this Subchapter.
(e) The Department shall mail a written report to the facility within 10 working days from the date of the licensure survey or complaint investigation exit conference. The report shall include statements of any deficiencies or violations cited during the survey or investigation.
(f) The administrator shall prepare a written plan of correction and mail it to the Department within 10 working days following receipt of any statement of deficiencies or violations. The Department shall review and accept or reject the plan of correction, with written notice given to the administrator within 10 working days following receipt of the plan.

History Note: *Authority G.S. 131E-104;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2110 PUBLIC ACCESS TO DEPARTMENT LICENSURE RECORDS

History Note: *Authority G.S. 8-53; 108A-80; 131E-104; 131E-124(c); 132-1.1;*
Eff. January 1, 1996;
Repealed Eff. July 1, 2012.

10A NCAC 13D .2111 ADMINISTRATIVE PENALTY DETERMINATION PROCESS

History Note: *Authority G.S. 131D-34; 131E-104; 143B-165;*
Eff. August 3, 1992;
Amended Eff. March 1, 1995;
Transferred and recodified from 10 NCAC 03H .0221 Eff. January 10, 1996;
Amended Eff. July 1, 2014;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015;
Repealed Eff. July 1, 2017.

SECTION .2200 - GENERAL STANDARDS OF ADMINISTRATION

10A NCAC 13D .2201 ADMINISTRATOR

(a) A facility shall be under the control of an administrator licensed by the North Carolina State Board of Examiners for Nursing Home Administrators.
(b) If an administrator is not the sole owner of a facility, his or her authority and responsibility shall be defined in a written agreement or in the facility's governing bylaws.
(c) The administrator shall be responsible for the operation of a facility.
(d) The administrator shall comply with the rules of this Subchapter.
(e) The administrator shall be responsible for developing and implementing policies for the management and operation of the facility as set forth in 21 NCAC 37B .0204, which is incorporated herein by reference including subsequent amendments and editions. These rules may be accessed free of charge at http://reports.oah.state.nc.us/ncac.asp.
(f) In the physical absence of the administrator, a person shall be on-site who is designated to be in charge of the facility operation.

History Note: *Authority G.S. 131E-104; 131E-116;*
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015;
Amended Eff. January 1, 2018.

10A NCAC 13D .2202 ADMISSIONS
(a) No patient shall be admitted except by a physician. Admission shall be in accordance with facility policies and procedures.
(b) The facility shall acquire, prior to or at the time of admission, orders for the immediate care of the patient from the admitting physician.
(c) Within 48 hours of admission, the facility shall acquire medical information which shall include current medical findings, diagnoses, and other information necessary to formalize the initial plan of care.
(d) Only persons who are 18 years of age or older shall be admitted to the adult care home portion of a combination facility.

History Note: *Authority G.S. 131E-104;*
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Amended Eff. January 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2203 PATIENTS NOT TO BE ADMITTED
(a) Patients who require health, habilitative or rehabilitative care beyond those for which the facility is licensed and is capable of providing shall not be admitted to the licensed nursing home.
(b) No person requiring continuous nursing care shall be admitted to an adult care home bed in a combination facility, except under emergency situations as described in Rule .2105 of this Subchapter. Should an existing resident of an adult care home bed require continuous nursing care, the facility shall either discharge the resident or provide the next available nursing facility bed (that is not needed to comply with G.S. 131E-130) to the resident to ensure continuity of care and to prevent unnecessary discharge from the facility.
(c) During the resident's stay in the adult care section of the combination facility, the facility shall ensure that necessary nursing services are provided. Should the facility be unable to provide necessary services the resident requires, whether in the adult care or nursing section, the facility shall follow discharge procedures according to Rule .2205 of this Subchapter.

History Note: *Authority G.S. 131E-104;*
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Amended Eff. January 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2204 RESPITE CARE

(a) Respite care is not required as a condition of licensure. Facilities providing respite care, however, shall meet the requirements of this Subchapter with the following exceptions: Rules .2205, .2301, and .2501(b) and (c) of this Subchapter.

(b) Facilities providing respite care shall meet the following additional requirements:

(1) A patient's descriptive record of stay shall include the preadmission or admission assessment, interdisciplinary notes as warranted by episodic events, medication administration records and a summary of the stay upon discharge.

(2) The facility shall complete a preadmission or admission assessment which allows for the development of a short-term plan of care and is based on the patient's customary routine. The assessment shall address needs, including but not limited to identifying information, customary routines, hearing, vision, cognitive ability, functional limitations, continence, special procedures and treatments, skin conditions, behavior and mood, oral and nutritional status and medication regimen. The plan shall be developed to meet the respite care patient's needs.

(3) The attending physician of the respite care patient will be notified of any acute changes or acute episode which warrant medical involvement. Medical orders and progress notes shall be written following the physician's visits.

History Note: Authority G.S. 131E-104;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2205 DISCHARGE OF PATIENTS

(a) The facility shall ensure a medical order for discharge is obtained for all patients except when a patient leaves against medical advice or is discharged for non-payment.

(b) The facility shall ensure discharge planning is accomplished according to each patient's needs when a discharge is anticipated.

(c) The facility shall ensure the patient or the legal representative is informed and included in the discharge planning process.

History Note: Authority G.S. 131E-104;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2206 MEDICAL DIRECTOR

(a) The facility shall designate a physician to serve as medical director.

(b) The medical director shall be responsible for implementation of patient care policies and coordination of medical care in the facility.

History Note: Authority G.S. 131E-104;
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2207 PATIENT RIGHTS

(a) The facility shall enforce the Nursing Facility Patient's Bill of Rights as described in G.S. 131E-115 through G.S. 131E-127.

(b) In matters of patient abuse, neglect or misappropriation the definitions shall have the meaning defined in Rule .2001 of this Subchapter.

History Note: Authority G.S. 131E-104; 131E-131;
Eff. January 1, 1996;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2208 SAFETY

(a) The facility shall have detailed written plans and procedures to meet potential emergencies and disasters, including but not limited to fire, severe weather and missing patients or residents.

(b) The plans and procedures shall be made available upon request to local or regional emergency management offices.

(c) The facility shall provide training for all employees in emergency procedures upon employment and annually.

(d) The facility shall conduct unannounced drills using the emergency procedures.

(e) The facility shall ensure that:

(1) the patients' environment remains as free of accident hazards as possible; and

(2) each patient receives adequate supervision and assistance to prevent accidents.

History Note: Authority G.S. 131E-104;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2209 INFECTION CONTROL

(a) A facility shall establish and maintain an infection control program for the purpose of providing a safe, clean and comfortable environment and preventing the transmission of diseases and infection.

(b) Under the infection control program, the facility shall decide what procedures, such as isolation techniques, are needed for individual patients, investigate episodes of infection and attempt to control and prevent infections in the facility.

(c) The facility shall maintain records of infections and of the corrective actions taken.

(d) The facility shall ensure communicable disease testing as required by 10A NCAC 41A, "Communicable Disease Control" which is incorporated by reference, including subsequent amendments. Copies of these Rules may be obtained at no charge by contacting the N.C. Department of Health and Human Services, Division of Public Health, Tuberculosis Control Branch, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. Screening shall be done upon admission of all patients being admitted from settings other than hospitals, nursing facilities or combination facilities. Staff shall be screened within seven days of the hire date. The facility shall ensure tuberculosis screening annually thereafter for patients and staff.

(e) All cases of reportable disease as defined by 10A NCAC 41A "Communicable Disease Control" and outbreaks consisting of two or more linked cases of disease transmission shall be reported to the local health department.

(f) The facility shall use isolation precautions for any patient deemed appropriate by its infection control program and as recommended by the following Centers for Disease Control guidelines, Management of Multidrug-Resistant Organisms In Healthcare Settings, 2006, http://www.cdc.gov/ncidod/dhqp/pdf/ar/MDROGuideline2006.pdf and 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, http://www.cdc.gov/hicpac/2007ip/2007isolationprecautions.html.

(g) The facility shall prohibit any employee with a communicable disease or infected skin lesion from direct contact with patients or their food, if direct contact is the mode of transmission of the disease.

(h) The facility shall require all staff to use hand washing technique as indicated in the Centers for Disease Control, "Guideline for Hand Hygiene in Health-Care Settings, Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force". This information can be accessed at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm.

(i) All linen shall be handled, store, processed and transported so as to prevent the spread of infection.

History Note: Authority G.S. 131E-104; 131E-113;
Eff. January 1, 1996;
Amended Eff. July 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2210 REPORTING AND INVESTIGATING ABUSE, NEGLECT OR MISAPPROPRIATION

(a) A facility shall take measures to prevent patient abuse, patient neglect, or misappropriation of patient property, including orientation and instruction of facility staff on patients' rights and the screening of and requesting of references for all prospective employees.
(b) A facility shall ensure that the Division of Health Service Regulation is notified within 24 hours of the facility's becoming aware of any allegation against health care personnel of any act listed in G.S. 131E-256(a)(1).
(c) A facility shall investigate allegations of any act listed in G.S. 131E-256(a)(1), shall document all information pertaining to such investigation, and shall take the necessary steps to prevent further incidents while the investigation is in progress.
(d) A facility shall ensure that the report of investigation is printed or typed and sent to the Division of Health Service Regulation within five working days of the allegation. The report shall include:

(1) the date and time of the alleged incident;
(2) the patient's full name and room number;
(3) details of the allegation and any injury;
(4) names of the accused and any witnesses;
(5) names of the facility staff who investigated the allegation;
(6) results of the investigation; and
(7) any corrective action that was taken by the facility.

History Note: *Authority G.S. 131E-104; 131E-131; 131E-255; 131E-256;*
Eff. January 1, 1996;
Amended Eff. July 1, 2014; February 1, 2013; August 1, 2008; October 1, 1998;
Readopted Eff. July 1, 2016.

10A NCAC 13D .2211 PERSONNEL STANDARDS
(a) The facility shall employ the types and numbers of qualified staff, professional and non-professional, necessary to provide for the health, safety and proper care of patients.
(b) Each employee shall be assigned duties consistent with his or her job description and with his or her level of education and training.
(c) Professional staff shall be licensed, certified or registered in accordance with applicable state laws.
(d) The facility shall provide orientation regarding facility policies and procedures for all staff upon employment.
(e) The facility shall train all staff periodically in accordance with their job duties.
(f) The facility shall maintain an individual personnel record for each employee, including verification of credentials.
(g) The facility shall have a written agreement with any nursing personnel agency providing staff to the facility and shall orient agency staff as to facility policies and procedures.

History Note: *Authority G.S.131E-104;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2212 QUALITY ASSURANCE COMMITTEE
(a) The administrator shall establish a quality assessment and assurance committee that consists of the director of nursing, a physician designated by the facility, a pharmacist and at least three other staff members.
(b) The committee shall meet at least quarterly.
(c) The committee shall develop and implement appropriate plans of action which will correct identified quality care problems.

History Note: *Authority G.S. 131E-104;*
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

SECTION .2300 - PATIENT AND RESIDENT CARE AND SERVICES

10A NCAC 13D .2301 PATIENT ASSESSMENT AND PLAN OF CARE

(a) At the time each patient is admitted, the facility shall ensure medical orders are available for the patient's immediate care and that, within 24 hours, a nursing assessment of immediate needs is completed by a registered nurse and measures implemented as appropriate.

(b) The facility shall perform, within 14 days of admission and at least annually, a comprehensive, accurate, documented assessment of each patient's capability to perform daily life functions. This comprehensive assessment shall be coordinated by a registered nurse and shall include at least the following:

- (1) current medical diagnoses;
- (2) medical status measurements, including current cognitive status, stability of current conditions and diseases, vital signs, and abnormal lab values and diagnostic tests that are a part of the medical history;
- (3) the patient's ability to perform activities of daily living, including the need for staff assistance and assistive devices, and the patient's ability to make decisions;
- (4) presence of neurological or muscular deficits;
- (5) nutritional status measurements and requirements, including but not limited to height, weight, lab work, eating habits and preferences, and any dietary restrictions;
- (6) special care needs, including but not limited to pressure sores, enteral feedings, specialized rehabilitation services or respiratory care;
- (7) indicators of special needs related to patient behavior or mood, interpersonal relationships and other psychosocial needs;
- (8) facility's expectation of discharging the patient within the three months following admission;
- (9) condition of teeth and gums, and need and use of dentures or other dental appliances;
- (10) patient's ability and desire to take part in activities, including an assessment of the patient's normal routine and lifetime preferences;
- (11) patient's ability to improve in functional abilities through restorative care;
- (12) presence of visual, hearing or other sensory deficits; and
- (13) drug therapy.

(c) The facility shall develop a comprehensive plan of care for each patient and shall include measurable objectives and timetables to meet needs identified in the comprehensive assessment. The facility shall ensure the comprehensive plan of care is developed within seven days of completion of the comprehensive assessment by an interdisciplinary team. To the extent practicable, preparation of the comprehensive plan of care shall include the participation of the patient and the patient's family or legal representative. The physician may participate by alternative methods, including, but not limited to, telephone or face-to-face discussion, or written notice.

(d) The facility shall review comprehensive assessments and plans of care no less frequently than once every 90 days and make necessary revisions to ensure accuracy.

History Note: *Authority G.S. 131E-104;*
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Amended Eff. February 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2302 NURSING SERVICES

(a) The facility shall designate a registered nurse to serve as the director of nursing on a full-time basis.

(b) The director of nursing shall be responsible for the administering of nursing services.

(c) The director of nursing may serve also as nurse-in-charge, only if the average daily occupancy is less than 60.

(d) The director of nursing shall not serve as administrator, assistant administrator or acting administrator during an employment vacancy in the administrator position.

History Note: *Authority G.S. 131E-104;*
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2303 NURSE STAFFING REQUIREMENTS

(a) A facility shall provide licensed nursing staff sufficient to accomplish the following:

(1) patient needs assessment;
(2) patient care planning; and
(3) supervisory functions in accordance with the levels of patient care advertised or offered by the facility.

(b) A facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the physical, mental, and psychosocial well-being of each patient, as determined by patient assessments and individual plans of care.

(c) A multi-storied facility shall have at least one nurse aide on duty on each patient care floor at all times.

(d) Except for designated units with higher staffing requirements noted elsewhere in this Subchapter, daily direct patient care nursing staff, licensed and unlicensed, shall include:

(1) at least one licensed nurse on duty for direct patient care at all times; and
(2) a registered nurse for at least eight consecutive hours a day, seven days a week. This coverage may be spread over more than one shift if such a need exists. The director of nursing may be counted as meeting the requirements for both the director of nursing and patient staffing for facilities with a total census of 60 nursing beds or less.

History Note: *Authority G.S. 131E-104; 131E-114.1;*
Eff. January 1, 1996;
Amended Eff. January 1, 2013;
Readopted Eff. July 1, 2016.

10A NCAC 13D .2304 NURSE AIDES

(a) A facility shall employ or contract individuals as nurse aides in compliance with N.C. General Statute 131E, Article 15 and facilities certified for Medicare or Medicaid participation shall also comply with 42 CFR Part 483 which is incorporated by reference, including subsequent amendments. The Code of Federal Regulations may be accessed at http://www.access.gpo.gov/nara/cfr/waisidx_08/42cfr483_08.

(b) A facility shall provide to the Department, upon request, verification of in-service training and of past or present employment of any nurse aide employed by the facility.

History Note: *Authority G.S. 131E-104; 131E-255; 143B-165; 42 U.S.C. 1395; 42 U.S.C. 1396;*
Eff. January 1, 1996;
Amended Eff. July 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2305 QUALITY OF CARE

(a) The facility shall provide necessary care and services in accordance with medical orders, the patient's comprehensive assessment and on-going plan of care.

(b) Acute changes in the patient's physical, mental or psychosocial status shall be evaluated and reported to the physician or other persons legally authorized to perform medical acts.

(c) The facility shall not utilize any chemical or physical restraints for the purpose of discipline or convenience, and that are not required to treat the patient's medical condition. An evaluation shall be done to ensure that the least restrictive means of restraint have been initiated on patients requiring restraints.

(d) The facility shall ensure that all patients who are unable to perform activities of daily living receive the necessary assistance to maintain good grooming, and oral and personal hygiene. The facility shall ensure appropriate measures are taken to restore the patient's ability to bathe, dress, groom, transfer and ambulate, toilet and eat.

(e) The facility shall ensure measures are taken to prevent the formation of pressure sores and to promote healing of existing pressure sores. The facility shall ensure that patients with limited mobility receive appropriate care to promote comfort and maintain skin integrity.

(f) The facility shall ensure that in-dwelling catheters are not used unless the patient's clinical condition necessitates their use. The facility shall ensure incontinent patients receive appropriate treatment to prevent infections and to regain continence to the degree possible.

(g) The facility shall ensure that patients with limited range of motion, or who are at risk for loss of range of motion, receive treatment services to prevent development of contractures or deformities, and to obtain and maintain their optimal level of functioning.
(h) The facility shall ensure that patients who are unable to feed themselves receive the appropriate assistance, retraining and assistive devices when needed.
(i) The facility shall ensure that enteral feeding tubes are used only when the patient's condition indicates the use of an enteral feeding tube is unavoidable.
(j) The facility shall ensure that patients fed by enteral feeding tubes receive the proper treatment to avoid aspiration pneumonia, metabolic and gastrointestinal problems, and to restore the patient to the highest practicable level of normal feeding function. The facility shall ensure appropriate care and services are provided to address needs related to hydration and nutrition.
(k) The facility shall ensure that patients requiring special respiratory care receive appropriate services.
(l) The facility shall ensure that patients are assisted to utilize personal visual lenses, hearing aids and dentures.

History Note: Authority G.S. 131E-104;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2306 MEDICATION ADMINISTRATION
(a) The facility shall ensure that medications are administered in accordance with applicable occupational licensure regulations and manufacturer's recommendations.
(b) The facility shall ensure that each patient's drug regimen is free from drugs used in excessive dose or duplicative therapy, for excessive duration or without indications for the prescription of the drug. Drugs shall not be used without monitoring or in the presence of adverse conditions that indicate the drugs' usage should be modified or discontinued. As used in this Paragraph:

(1) "Excessive dose" means the total amount of any medication (including duplicate therapy) given at one time or over a period of time that is greater than the amount recommended by the manufacturer for a resident's age and condition.
(2) "Excessive Duration" means the medication is administered beyond the manufacturer's recommended time frames or facility-established stop order policies or without either evidence of additional therapeutic benefit for the resident or clinical evidence that would warrant the continued use of the medication.
(3) "Duplicative Therapy" means multiple medications of the same pharmacological class or category or any medication therapy that replicates a particular effect of another medication that the individual is taking.
(4) "Indications for the prescription" means a documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and is consistent with manufacturer's recommendations.
(5) "Monitoring" means ongoing collection and analysis of information (such as observations and diagnostic test results) and comparison to baseline data in order to:
    (A) Ascertain the individual's response to treatment and care, including progress or lack of progress toward a therapeutic goal;
    (B) Detect any complications or adverse consequences of the condition or of the treatments; and
    (C) Support decisions about modifying, discontinuing, or continuing any interventions.

(c) Antipsychotic therapy shall not be initiated on any patient unless necessary to treat a clinically diagnosed and clinically documented condition. When antipsychotic therapy is prescribed, unless clinically contraindicated, gradual dose reductions and behavioral interventions shall be employed in an effort to discontinue these drugs. "Gradual dose reduction" means the stepwise tapering of a dose to determine if symptoms, conditions or risks can be managed by a lower dose or if the dose or the medication can be discontinued.
(d) The facility shall ensure that procedures aimed at minimizing medication error rates include the following:

(1) All medications or drugs and treatments shall be administered and discontinued in accordance with signed medical orders which are recorded in the patient's medical record. Such orders shall be complete and include drug name, strength, quantity to be administered, route of administration, frequency and, if ordered on an as-needed basis, a stated indication for use.

(2) The requirements for self-administration of medication shall include the following:
 (A) determination by the interdisciplinary team that this practice is safe;
 (B) administration ordered by the physician or other person legally authorized to prescribe medications;
 (C) instructions for administration printed on the medication label; and
 (D) administration of medication monitored by the nursing staff and consultant pharmacist.

(3) The administration of one patient's medications to another patient is prohibited except in the case of an emergency. In the event of such emergency, the facility shall ensure that the borrowed medications are replaced and so documented.

(4) Omission of medications and the reason for omission shall be indicated in the patient's medical record.

(5) Medication administration records shall provide time of administration, identification of the drug and strength of drug, quantity of drug administered, route of administration, frequency, documentation sufficient to determine the staff who administered the drugs. Medication administration records shall indicate documentation of injection sites and topical medication sites requiring rotation of transdermal medication.

(6) The pharmacy shall receive an exact copy of each physician's order for medications and treatments.

(7) When medication orders do not state the number of doses or days to administer the medication, the facility shall implement automatic stop orders according to manufacturer's recommendations.

(8) The facility shall maintain an accountability of controlled substances as defined by the North Carolina Controlled Substances Act, G.S. 90, Article 5.

History Note: *Authority G.S. 131E-104;*
Eff. January 1, 1996;
Amended Eff. January 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2307 DENTAL CARE AND SERVICES

(a) The facility shall ensure that routine and emergency dental services are available for all patients.

(b) The facility shall, if necessary, assist the patient in making appointments and obtaining transportation to the dentist's office.

History Note: *Authority G.S. 131E-104;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2308 ADULT CARE HOME PERSONNEL REQUIREMENTS

(a) The administrator of a combination home shall designate a person to be in charge of the adult care home residents at all times. The nurse-in-charge of the nursing facility may also serve as supervisor-in-charge of the domiciliary beds.

(b) If adult care home beds are located in a separate building or a separate level of the same building, there shall be a person on duty in the adult care home portion of the facility at all times.

History Note: *Authority G.S. 131E-104;*
RRC Objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Amended Eff. July 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2309 CARDIO-PULMONARY RESUSCITATION

(a) Each facility shall develop and implement a Cardio-Pulmonary Resuscitation (CPR) policy.

(b) The policy shall be communicated to all residents or their responsible party prior to admission.

(c) Upon admission each resident or his or her responsible party must acknowledge in writing having received a copy of the policy.
(d) The policy shall designate an outside emergency medical service provider to be immediately notified whenever an emergency occurs.
(e) The policy shall designate the level of CPR that is available using terminology defined by the American Heart Association. American Heart Association terminology is as follows:

(1) Heartsaver CPR;
(2) Heartsaver Automatic External Defibrillator (AED);
(3) Basic Life Support (BLS); or
(4) Advanced Cardiac Life Support (ACLS).

(f) The facility shall maintain staff on duty 24 hours a day trained by someone with valid certification from the American Heart Association or American Red Cross capable of providing CPR at the level stated in the policy. The facility shall maintain a record in the personnel file of each staff person who has received CPR training.
(g) The facility shall have equipment readily available as required to deliver services stated in the policy.
(h) The facility shall provide training for staff members who are responsible for providing CPR with regards to the location of resources and measures for self- protection while administering CPR.

History Note: Authority G.S. 131E-104;
Eff. October 1, 2006;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

SECTION .2400 - MEDICAL RECORDS

10A NCAC 13D .2401 MAINTENANCE OF MEDICAL RECORDS

(a) The facility shall establish a medical records service. It shall be directed, staffed and equipped to ensure:

(1) records are processed, indexed and filed accurately;
(2) records are stored in such a manner as to provide protection from loss, damage or unauthorized use;
(3) records contain sufficient information to identify the patient plus a record of all assessments; plan of care; pre-admission screening, if applicable; records of implementation of plan of care; progress notes; and record of discharge, including a discharge summary signed by the physician; and
(4) records are readily accessible by authorized personnel.

(b) The facility shall ensure that a master patient index is maintained, listing patients alphabetically by name, dates of admission, dates of discharge and case number.
(c) The administrator shall designate an employee who works full-time to be the medical records manager. The manager shall advise, administer, supervise and perform work involved in the development, analysis, maintenance and use of medical records and reports. If that employee is not qualified by training or experience in medical record science, he or she shall receive consultation from a registered records administrator or an accredited medical record technician to ensure compliance with rules contained in this Subchapter. The facility shall provide orientation, on-the-job training and in-service programs for all medical records personnel.

History Note: Authority G.S. 131E-104;
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2402 PRESERVATION OF MEDICAL RECORDS

(a) A facility shall keep medical records on file for five years following the discharge of an adult patient.
(b) Not withstanding Paragraph (c) of this Rule, if the patient is a minor when discharged from the nursing facility, the records shall be kept on file until his or her 19th birthday and for the additional time specified in G.S. 1-17(b) for commencement of an action on behalf of a minor.
(c) If a facility discontinues operation, the licensee shall inform the Division of Health Service Regulation where its records are stored. For five years after a facility discontinues operations, records shall be stored with a business offering medical record storage and retrieval services.

(d) All medical records are confidential. A facility shall comply with 42 CFR Parts 160, 162 and 164 of the Health Insurance Portability and Accountability Act.
(e) At the time of the inspection, a facility shall inform the surveyor of the name of any patient who has denied the Department access to his or her medical record pursuant to G.S. 131E-105.

History Note: Authority G.S. 131E-104; 131E-105;
Eff. January 1, 1996.
Amended Eff. November 1, 2014;
Readopted Eff. July 1, 2016.

SECTION .2500 - PHYSICIAN'S SERVICES

10A NCAC 13D .2501 AVAILABILITY OF PHYSICIAN'S SERVICES

(a) The facility shall ensure each patient's care is supervised by a physician and that provisions are made for emergency physicians when attending physicians are unavailable. The names and telephone numbers of the designated physicians shall be posted at each nurse's station.
(b) Patients shall be seen by a physician at least once every 30 days for the first 90 days and at least every 60 days thereafter. Following the initial visit, the physician may delegate this responsibility to a physician assistant or nurse practitioner every other visit. A physician's visit is considered timely if the visit occurs not later than 10 days after the visit was required.
(c) Physicians shall review the patient's medical plan of care, write or dictate and sign progress notes; and sign and date all current orders at each visit.
(d) Medical orders, given orally by the physician, nurse practitioner or physician assistant, shall be given only to a licensed nurse or other licensed professional who by law is allowed to accept physician's orders, except orders for therapeutic diets which shall be given either to a dietitian or licensed nurse. The record of each telephone order shall include the name of physician giving the order, or other person legally authorized to prescribe, date and time of order, content of order and name of person receiving the order. The physician, or other person legally authorized to prescribe, who gives oral orders shall sign the orders within five days.

History Note: Authority G.S. 131E-104;
RRC objection due to lack of statutory authority and ambiguity Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2502 PRIVATE PHYSICIAN

(a) Each patient or legal representative shall be allowed to select his or her private physician except in those facilities affiliated with medical teaching programs and having written policies requiring all patients to participate in the medical teaching program.
(b) The private physician shall fulfill given requirements as determined by applicable state and federal regulations, and the facility's policies and procedures pertaining to physician services.
(c) The facility shall have the right, after informing the patient, to seek an alternative physician, when requirements are not being met and to ensure that the patient is provided with appropriate, adequate care and treatment.

History Note: Authority G.S. 131E-104;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2503 USE OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

(a) Any facility that employs nurse practitioners or physician assistants shall maintain the following information for each nurse practitioner and physician assistant:

(1) verification of current approval to practice as a nurse practitioner by the Medical Board and Board of Nursing for each practitioner, or verification of current approval to practice as a physician assistant by the Medical Board for each physician assistant; and

(2) a copy of the job description or contract signed by the nurse practitioner or physician assistant and the supervising physicians.

(b) The privileges of the nurse practitioner or physician assistant shall be defined by the facility's policies and procedures, and shall be limited to those privileges authorized in 21 NCAC 36 .0802 and .0809 for the nurse practitioner or 21 NCAC 32S .0212 for the physician assistant.

History Note: Authority G.S. 131E-104;
Eff. January 1, 1996;
Amended Eff. November 1, 2014;
Readopted Eff. July 1, 2016.

10A NCAC 13D .2504 LABORATORY AND RADIOLOGY SERVICES

The facility shall provide or obtain clinical laboratory and radiology services to ensure that each patient's needs are met. Such services shall include the following:

(1) provision of laboratory and radiology services within the facility or by contractual agreement;
(2) diagnostic testing to be done only in accordance with a medical order;
(3) reports to be dated once filed in the patient's medical record;
(4) notification of the physician, nurse practitioner or physician assistant regarding findings; and
(5) assistance in arranging transportation for the patient when testing must be done other than in the facility.

History Note: Authority G.S. 131E-104;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2505 BRAIN INJURY LONG-TERM CARE PHYSICIAN SERVICES

(a) For facility patients located in designated brain injury long-term care units, there shall be an attending physician who is responsible for the patient's specialized care program. The intensity of the program requires that there shall be direct patient contact by a physician at least once per week and more often as the patient's condition warrants. Each patient's interdisciplinary, rehabilitation program shall be developed and implemented under the supervision of a physiatrist (a physician trained in physical medicine and rehabilitation) or a physician of equivalent training and experience.

(b) If a physiatrist or physician of equivalent training or experience is not available on a weekly basis to the facility, the facility shall provide for weekly medical management of the patient by another physician. In addition, oversight for the patient's interdisciplinary, long-term care program shall be provided by a qualified consultant physician who visits patients monthly, makes recommendations for and approves the interdisciplinary care plan, and provides consultation as requested to the physician who is managing the patient on a weekly basis.

(c) The attending physician shall actively participate in individual case conference or care planning sessions and shall review and sign discharge summaries and records within 15 days of a patient discharge. When patients are to be discharged to either another health care facility or a residential setting, the attending physician shall ensure that the patient has been provided with a discharge plan which incorporates optimum utilization of community resources and post discharge continuity of care and services.

History Note: Authority G.S. 131E-104;
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2506 PHYSICIAN SERVICES FOR VENTILATOR DEPENDENT PATIENTS

History Note: Authority G.S. 131E-104;
RRC objection due to lack of statutory authority and ambiguity Eff. July 13, 1995;
Eff. January 1, 1996;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015;
Repealed Eff. January 1, 2021.

SECTION .2600 - PHARMACEUTICAL SERVICES

10A NCAC 13D .2601 AVAILABILITY OF PHARMACEUTICAL SERVICES

(a) The facility shall provide pharmaceutical services under the supervision of a pharmacist, including procedures that ensure the accurate acquiring, receiving and administering of all drugs and biologicals.
(b) The facility shall be responsible for obtaining drugs, therapeutic nutrients and related products prescribed or ordered by a physician for patients in the facility.
(c) To ensure that drug therapy is rational, safe and effective, a pharmaceutical care assessment shall be conducted in the facility at least every 31 days for each patient. All new admissions shall receive a pharmaceutical care assessment at the time of the pharmacist's next visit or within 31 days, whichever comes first. This assessment shall include at least:

(1) a review of the patient's diagnoses, history and physical, discharge summary, diet, vital signs, current physician's orders, laboratory values, progress notes, interdisciplinary care plans and medication administration records; and
(2) the pharmacist's progress notes in the patient's medical record which reflect the results of this assessment and, if necessary, recommendations for change based on desired drug outcomes.

History Note: *Authority G.S. 131E-104; 131E-117;*
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2602 PHARMACY PERSONNEL

(a) If the pharmacist is an employee of the facility and performs vending or clinical services, an up-to-date job description and personnel file shall be maintained.
(b) If pharmaceutical vending or clinical services are contracted, there shall be a current written agreement for each service which includes a statement of responsibilities for each party.
(c) The facility shall keep, or be able to make available, a copy of the current license of the pharmacists.

History Note: *Authority G.S. 131E-104; 131E-117;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2603 ADMINISTRATIVE RESPONSIBILITIES

(a) The pharmacist shall report any potential drug therapy irregularities or discrepancies in drug accountability and administration with recommendations for change to the director of nursing and the attending physician. Recommendations shall be communicated to the health care professionals in the facility who have the authority to effect a change. These reports shall be submitted monthly following the pharmacist's pharmaceutical care assessments.
(b) The administrator shall ensure documentation of action taken relative to the pharmacist's reports.

History Note: *Authority G.S. 131E-104; 131E-117;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2604 DRUG PROCUREMENT

(a) The facility shall not possess a stock of prescription drugs for general or common use except as permitted by the North Carolina Board of Pharmacy and as follows:

(1) for all intravenous and irrigation solutions in single unit quantities exceeding 49 ml. and related equipment for the use and administration of such;
(2) diagnostic agents;
(3) vaccines;
(4) drugs designated for inclusion in an emergency kit approved by the facility's Quality Assurance Committee;
(5) water for injection; and
(6) normal saline for injection.

(b) Patient Drugs:
(1) The contents of all prescriptions shall be kept in the original container bearing the original label as described in Subparagraph (b)(2) of this Rule.
(2) Except in a 72-hour or less unit dose system, each individual patient's prescription drugs shall be labeled with the following information:
(A) the name of the patient for whom the drug is intended;
(B) the most recent date of issue;
(C) the name of the prescriber;
(D) the name and concentration of the drug, quantity dispensed, and prescription serial number;
(E) a statement of generic equivalency which shall be indicated if a brand other than the brand prescribed is dispensed;
(F) the expiration date, unless dispensed in a single unit or unit dose package;
(G) auxiliary statements as required of the drug;
(H) the name, address and telephone number of the dispensing pharmacy; and
(I) the name of the dispensing pharmacist.

(c) Non-prescription drugs shall be kept in the original container as received from the supplier and shall be labeled with at least:
(1) the name and concentration of the drug, and quantity packaged;
(2) the name of the manufacturer, lot number and expiration date.

History Note: *Authority G.S. 131E-104; 131E-117;*
Eff. January 1, 1996;
Amended Eff. January 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2605 DRUG STORAGE AND DISPOSITION

(a) A facility shall ensure that drug storage areas are clean, secure, well lighted and well ventilated; that room temperature is maintained between 59 degrees F. and 86 degrees F.; and that the following conditions are met:
(1) All drugs shall be maintained under locked security except when under the direct physical supervision of a nurse or pharmacist.
(2) Drugs requiring refrigeration shall be stored in a refrigerator containing a thermometer and capable of maintaining a temperature range of 2 degrees C. to 8 degrees C. (36 degrees F. to 46 degrees F.) Drug containers must be placed in another container separate from non-drug items when stored in a refrigerator.
(3) Drugs intended for topical use, except for ophthalmic, otic and transdermal medications, shall be stored in an area separate from the drugs intended for oral and injectable use.
(4) Drugs that are outdated, discontinued or deteriorated shall be removed from the facility within five days.

(b) Upon discontinuation of a drug or upon discharge of a patient, the remainder of the drug supply shall be disposed of according to the facility's policy. If it is reasonably expected that the patient will return to the facility and that the drug therapy will be resumed, the remaining drug supply may be held for not more than 30 calendar days after the date of discharge or discontinuation.

(c) The disposition of drugs shall be in accordance with written policies and procedures established by the Quality Assurance Committee.

(d) Destruction of controlled substances shall be in compliance with Disposal of Unused Controlled Substances From Nursing Home as described in 10A NCAC 26E .0406, which is hereby incorporated by reference including subsequent amendments. These Rules can be accessed online at http://reports.oah.state.nc.us/ncac.asp.

History Note: Authority G.S. 131E-104; 131E-117;
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Amended Eff. July 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2606 PHARMACEUTICAL RECORDS

(a) A facility shall ensure that accurate records of the receipt, use and disposition of drugs are maintained and readily available.
(b) A facility shall ensure accountability of controlled substances as defined by the Disposal of Unused Controlled Substances From Nursing Home as described in 10A NCAC 26E .0406, which is hereby incorporated by reference including subsequent amendments. These Rules can be accessed online at http://reports.oah.state.nc.us/ncac.asp.

History Note: Authority G.S. 131E-104; 131E-117;
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Amended Eff. July 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2607 EMERGENCY DRUGS

(a) A facility shall maintain a supply of emergency drugs in compliance with 10A NCAC 26E .0408 which is hereby incorporated by reference including subsequent amendments. This Rule can be accessed online at http://reports.oah.state.nc.us/ncac.asp.
(b) Emergency drugs shall be stored in a portable container sealed with an easily breakable closure which cannot be resealed or reused and shall be readily accessible for use.
(c) Emergency drug kits shall be stored in a locked storage cabinet or room out of sight of patients and the general public. If stored in a locked area the kits shall be accessible to all licensed nursing personnel.
(d) All emergency drugs and quantity to be maintained shall be approved by the Quality Assurance Committee as defined in 10A NCAC 13D .2212.
(e) If emergency drug items require refrigerated storage, they shall be stored in a separate sealed container within the medication refrigerator. The container shall be labeled to indicate the emergency status of the enclosed drug and sealed as indicated in Paragraph (b) of this Rule.
(f) An accurate inventory of emergency drugs and supplies shall be maintained with each emergency drug kit.
(g) A facility shall examine the refrigerated and non-refrigerated emergency drug supply at least every 90 days and make any necessary changes at that time.
(h) The facility shall have written policies and procedures which are enforced to ensure that in the event the sealed emergency drug container is opened and contents utilized, steps are taken to replace the items used.
(i) The availability of a controlled substance in an emergency kit shall be in compliance with the North Carolina Controlled Substances Act and Regulations (10A NCAC 26E) which is hereby incorporated by reference including subsequent amendments. These Rules can be accessed online at http://reports.oah.state.nc.us/ncac.asp.

History Note: Authority G.S. 131E-104; 131E-117;
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Amended Eff. July 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

SECTION .2700 - DIETARY SERVICES

10A NCAC 13D .2701 PROVISION OF NUTRITION AND DIETETIC SERVICES

(a) A facility shall ensure that each patient is provided with a palatable diet that meets his or her daily nutritional and specialized nutritional needs.

(b) The facility shall designate a person to be known as the director of food service who shall be responsible for the facility's dietetic service and for supervision of dietetic service personnel.

(c) Based on a resident's assessment, the nursing home must ensure that a patient maintains nutritional status, such as body weight and protein levels, unless the patient's clinical condition demonstrates that it is not possible.

(d) There shall be sufficient personnel employed to meet the nutritional needs of all patients in the areas of therapeutic diets, food preparation and service, principles of sanitation, and resident's preferences as related to food services.

(e) The facility shall ensure that menus are followed which meet the nutritional needs of patients in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences which are incorporated by reference, including subsequent amendments. Copies of this publication may be obtained by contacting The National Academy Press, 500 Fifth St. N.W., Washington, D.C. 20001 or accessing it at http://www.nap.edu/catalog.php?record_id=1349. Menus shall:

(1) be planned at least 14 days in advance,

(2) provide for substitutes of similar nutritive value for patients who refuse food that is served, and

(3) be provided to patients orally or written through such methods as posting and daily announcements.

(f) Food must be prepared to conserve its nutritive value and appearance.

(g) Food shall be served at the preferred temperature as discerned by the resident and customary practice, in a form to meet the patient's individual needs and with assistive devices as dictated by the patient's needs. Hot foods shall leave the kitchen (or steam table) above 135 degrees F; and cold foods below 41 degrees F. The freezer must keep frozen foods frozen solid.

(h) If patients require assistance in eating, food shall be maintained at the appropriate temperature until assistance is provided.

(i) All diets, including enteral and parenteral nutrition therapy, shall be as ordered by the physician or other legally authorized person, and served as ordered.

(j) At least three meals shall be served daily to all patients in accordance with medical orders.

(k) No more than 14 hours shall elapse between an evening meal containing a protein food and a morning meal containing a protein food.

(l) Hour-of-sleep (hs) nourishment shall be available to patients upon request or in accordance with nutritional plans.

(m) Between-meal fluids for hydration shall be available and offered to all patients in accordance with medical orders.

(n) The facility shall have a current online or hard copy nutrition care manual or handbook approved by the dietitian, medical staff and the Administrator which shall be used in the planning of the regular and therapeutic diets and be accessible to all staff.

(o) Food services shall comply with Rules Governing the Sanitation of Restaurants and Other Foodhandling Establishments (15A NCAC 18A .1300) as promulgated by the Commission for Public Health which are incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food under sanitary conditions. Copies of these Rules can be accessed online at http://www.deh.enr.state.nc.us/rules.htm.

History Note: *Authority G.S. 90-368(4); 131E-104;*
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Amended Eff. August 1, 2012;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

SECTION .2800 - ACTIVITIES, RECREATION AND SOCIAL SERVICES

10A NCAC 13D .2801 ACTIVITY SERVICES

(a) The facility shall provide a program of activities that is on-going and in accordance with the comprehensive assessment, and that promotes the interests, as well as physical, mental and psychosocial well-being, of each patient.

(b) The administrator shall designate an activities director who shall be responsible for activity and recreational services for all patients and who shall have appropriate management authority. The director shall:

(1) be a recreation therapist or be eligible for certification as a therapeutic recreation specialist by a recognized accrediting body; or
(2) have two years of experience in a social or recreation program within the last five years, one of which was full-time in a patient activities program in a health care setting; or
(3) be an occupational therapist or occupational therapy assistant; or
(4) be certified by the National Certification Council for Activity Professionals; or
(5) have completed an activities training course approved by the State.

History Note: Authority G.S. 131E-104; 143B-165(10); 42 C.F.R. 483.15(f);
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2802 SOCIAL SERVICES

(a) The facility shall provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.
(b) The administrator shall designate an employee to be responsible full-time for social services.
(c) A facility with more than 120 nursing beds shall employ on a full time basis, a social worker who has:

(1) a Bachelors' degree in social work or a Bachelors' degree in human services field, including but not limited to sociology special education, rehabilitation counseling and psychology; and
(2) one year of supervised social work experience in a health care setting working directly with patients.

History Note: Authority G.S. 131E-104;
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

SECTION .2900 - SPECIAL REQUIREMENTS

10A NCAC 13D .2901 REPORT OF DEATH

The facility shall have a written plan to be followed in case of patient death. The plan shall provide for the following:

(1) collection of data needed for the death certificate as required by G.S. 130A-117;
(2) recording time of death;
(3) pronouncement of death in accordance with facility policy;
(4) notification of the attending physician responsible for signing the death certificate;
(5) documented notification of next of kin or legal guardian;
(6) authorization and release of the body to a funeral home.

History Note: Authority G.S. 131E-104;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .2902 PETS

When facility policies permit pets in the facility, the following conditions shall be met:

(1) The facility policy shall not be in violation of any local health ordinances regarding pet health and control.
(2) Pets shall not be permitted to enter areas where food is being prepared.

History Note: Authority G.S. 131E-104;

Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

SECTION .3000 - SPECIALLY DESIGNATED UNITS

10A NCAC 13D .3001 SPECIALIZED REHABILITATIVE AND HABILITATIVE SERVICES
10A NCAC 13D .3002 QUALITY OF SPECIALIZED REHABILITATION SERVICES

History Note: *Authority G.S. 131E-104;*
RRC objection due to lack of statutory authority Eff. July 13, 1995 (Rule .3002);
Eff. January 1, 1996;
Repealed Eff. January 1, 2013.

10A NCAC 13D .3003 VENTILATOR ASSISTED CARE

(a) For the purpose of this Rule, ventilator assisted individuals, means as defined in the federal State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities, herein incorporated by reference including subsequent amendments and editions. Copies of the State Operations Manual may be accessed free of charge online at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.

(b) Facilities having patients who are ventilator assisted individuals shall:

(1) administer respiratory care in accordance with 42 CFR Part 483.25(i), and the federal State Operations Manual F695;

(2) administer respiratory care in accordance with the scope of practice for respiratory therapists defined in G.S. 90-648; and

(3) provide pulmonary services from a physician who has training in pulmonary medicine. The physician shall be responsible for respiratory services and shall:

(A) establish with the respiratory therapist and nursing staff, ventilator policies and procedures, including emergency procedures;

(B) assess each ventilator assisted patient's status at least monthly with corresponding progress notes;

(C) respond to emergency communications 24 hours a day; and

(D) participate in individual care planning.

(c) Direct care nursing personnel staffing ratios established in Rule .2303 of this Subchapter shall not be applied to nursing services for patients who are ventilator assisted at life support settings. The minimum direct care nursing staff shall be 5.5 hours per patient day, allocated on a per shift basis as the facility chooses; however, in no event shall the direct care nursing staff fall below a registered nurse and a nurse aide I at any time during a 24-hour period.

History Note: *Authority G.S. 131E-104;*
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015;
Amended Eff. January 1, 2021.

10A NCAC 13D .3004 BRAIN INJURY LONG-TERM CARE

(a) The general requirements in this Subchapter shall apply when applicable, but brain injury long term care units shall meet the supplement requirements in Rules .3004 and .3005 of this Section. The facility shall provide services through a medically supervised interdisciplinary process as provided in Rule .2505 of this Subchapter and that are directed toward maintaining the individual at the optimal level of physical, cognitive and behavioral functioning. Following are the minimum requirements for specific services that may be necessary to maintain the individual at optimum level:

(1) Overall supervisory responsibility for brain injury long term care services shall be assigned to a registered nurse with one year experience in caring for brain injured patients.

(2) Physical therapy shall be provided by a physical therapist with a current valid North Carolina license. Occupational therapy shall be provided by an occupational therapist with a current valid

North Carolina License. The services of a physical therapist and occupational therapist shall be combined to provide one full-time equivalent position for each 20 patients. The assistance of a physical therapy aide and occupational therapy aide, with appropriate supervision, shall be combined to provide one full-time equivalent position for each 20 patients. A proportionate number of hours shall be provided for a census less than 20 patients.

(3) Clinical nutrition services shall be provided by a dietitian with two years clinical training and experience in nutrition. The number of hours of clinical nutrition services on either a full-time or part-time employment or contract basis shall be adequate to meet the needs of the patients. Each patient's nutrition needs shall be reviewed at least monthly. Clinical nutrition services shall include:
   (A) Assessing the appropriateness of the ordered diet for conformance with each patient's physiological and pharmacological condition.
   (B) Evaluating each patient's laboratory data in relation to nutritional status and hydration.
   (C) Applying technical knowledge of feeding tubes, pumps and equipment to each patient's specialized needs.

(4) Clinical social work shall be provided by a social worker meeting the requirements of Rule .2802 of this Subchapter.

(5) Recreation therapy, when required, shall be provided on either a full-time or part-time employment or contract basis by a clinician eligible for certification as a therapeutic recreation specialist by the State of North Carolina Therapeutic Recreational Certification Board. The number of hours of therapeutic recreation services shall be adequate to meet the needs of the patients. In event that a qualified specialist is not locally available, alternate treatment modalities shall be developed by the occupational therapist and reviewed by the attending physician. The program designed shall be adequate to meet the needs of this specialized population and shall be administered in accordance with Section .3000 of this Subchapter.

(6) Speech therapy, when required, shall be provided by a clinician with a current valid license in speech pathology issued by the State Board of Speech and Language Pathologists and Audiologists.

(7) Respiratory therapy, when required, shall be provided by an individual meeting the same qualifications for providing respiratory therapy under Rule .3003 of this Section.

(b) Each patient's program shall be governed by an interdisciplinary treatment plan incorporating and expanding upon the health plan required under Section .2300 of this Subchapter. The plan is to be initiated on the first day of admission. Upon completion of baseline data development and an integrated interdisciplinary assessment, the initial treatment plan is to be expanded and finalized within 14 days of admission. Through an interdisciplinary process the treatment plan shall be reviewed at least monthly and revised as appropriate. In executing the treatment plan, the interdisciplinary team shall be the major decision making body and shall determine the goals, process, and time frames for accomplishment of each patient's program. Disciplines to be represented on the team shall be medicine, nursing, clinical pharmacy and all other disciplines directly involved in the patient's treatment or treatment plan.

(c) Each patient's overall program shall be assigned to an individually designated case manager. The case manager acts as the coordinator for assigned patients. Any professional staff member involved in a patient's care may be assigned this responsibility for one or more patients. Professional staff may divide this responsibility for all patients on the unit in the best manner to meet all patients' needs for a coordinated, interdisciplinary approach to care. This case manager shall be responsible for:

(1) coordinating the development, implementation and periodic review of the patient's treatment plan;
(2) preparing a monthly summary of the patient's progress;
(3) cultivating the patient's participation in the program;
(4) general supervision of the patient during the course of treatment;
(5) evaluating appropriateness of the treatment plan in relation to the attainment of stated goals; and
(6) assuring that discharge decisions and arrangements for post discharge follow-up are properly made.

(d) For each 20 patients or fraction thereof, dedicated treatment facilities and equipment shall be provided as follows:

(1) a combined therapy space equal to or exceeding 600 square feet, adequately equipped and arranged to support each of the therapies;
(2) access to one full reclining wheel chair per patient;

(3) special physical therapy and occupational therapy equipment for use in fabricating positioning devices for beds and wheelchairs including splints, casts, cushions, wedges, and bolsters; and
(4) roll-in bath facilities with a dressing area available to all patients, providing maximum privacy to the patient.

History Note: Authority G.S. 131E-104;
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .3005 SPECIAL NURSING REQUIREMENTS FOR BRAIN INJURY LONG-TERM CARE

Direct care nursing personnel staffing ratios established in Rule .2303 of this Subchapter shall not be applied to nursing services for patients who require brain injury long-term care. The minimum direct care nursing staff shall be 5.5 hours per patient day, allocated on a per shift basis as the facility chooses, to appropriately meet the patients' needs. It is also required that regardless of how low the patient census, the direct care nursing staff shall not fall below a registered nurse and a nurse aide I at any time during a 24-hour period.

History Note: Authority G.S. 131E-104;
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .3006 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .3007 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .3008 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .3009 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .3010 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .3011 HIV DESIGNATED UNIT POLICIES AND PROCEDURES
10A NCAC 13D .3012 PHYSICIAN SERVICES IN AN HIV DESIGNATED UNIT
10A NCAC 13D .3013 SPECIAL NURSING REQUIREMENTS FOR AN HIV DESIGNATED UNIT
10A NCAC 13D .3014 SPECIALIZED STAFF EDUCATION FOR HIV DESIGNATED UNITS
10A NCAC 13D .3015 USE OF INVESTIGATIONAL DRUGS FOR HIV DESIGNATED UNITS
10A NCAC 13D .3016 ADDITIONAL SOCIAL WORK REQUIREMENTS FOR HIV DESIGNATED UNITS

History Note: Authority G.S. 131E-104;
RRC objection due to ambiguity Eff. July 13, 1995 (Rules .3011, .3012);
RRC objection due to lack of statutory authority and ambiguity Eff. July 13, 1995 (Rule .3013);
RRC objection due to lack of statutory authority Eff. July 13, 1995 (Rules .3015, .3016);
Eff. January 1, 1996;
Repealed Eff. January 1, 2013.

10A NCAC 13D .3017 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .3018 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .3019 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .3020 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .3021 PHYSICIAN REQUIREMENTS FOR INPATIENT REHABILITATION FACILITIES OR UNITS
10A NCAC 13D .3022 ADMISSION CRITERIA FOR INPATIENT REHABILITATION FACILITIES OR UNITS
10A NCAC 13D .3023 COMPREHENSIVE INPATIENT REHABILITATION EVALUATION
10A NCAC 13D .3024 COMPREHENSIVE INPATIENT REHABILITATION INTERDISCIPLINARY TREAT/PLAN
10A NCAC 13D .3025 DISCHARGE CRITERIA FOR INPATIENT REHABILITATION FACILITIES OR UNITS
10A NCAC 13D .3026 COMPREHENSIVE REHABILITATION PERSONNEL ADMINISTRATION
10A NCAC 13D .3027 COMPREHENSIVE INPATIENT REHABILITATION PROGRAM STAFFING REQUIREMENTS
10A NCAC 13D .3028 STAFF TRAINING FOR INPATIENT REHABILITATION FACILITIES OR UNIT
10A NCAC 13D .3029 EQUIPMENT REQS/COMPREHENSIVE INPATIENT REHABILITATION PROGRAMS
10A NCAC 13D .3030 PHYSICAL FACILITY REQS/INPATIENT REHABILITATION FACILITIES OR UNIT

History Note: *Authority G.S. 131E-104;*
RRC objection due to lack of statutory authority Eff. July 13, 1995 (Rules .3021, .3027);
Eff. January 1, 1996;
Repealed Eff. January 1, 2013.

10A NCAC 13D .3031 ADDITIONAL REQUIREMENTS FOR SPINAL CORD INJURY PATIENTS

Inpatient rehabilitation facilities providing services to persons with spinal cord injuries shall meet the requirements in this Rule in addition to those identified in this Section.

(1) Direct-care nursing personnel staffing ratios established in Rule .3027 of this Section shall not be applied to nursing services for spinal cord injury patients in the inpatient rehabilitation facility or unit. The minimum nursing hours per spinal cord injury patient in the unit shall be 6.0 nursing hours per patient day. At no time shall direct care nursing staff be less than two full-time equivalents, one of which shall be a registered nurse.
(2) The inpatient rehabilitation facility or unit shall employ or provide by contractual agreements physical, occupational or speech therapists in order to provide a minimum of 4.0 hours of specific or combined rehabilitation therapy services per spinal cord injury patient day.
(3) The facility shall provide special facility or special equipment needs of patients with spinal cord injury, including specially designed wheelchairs, tilt tables and standing tables.
(4) The medical director of an inpatient spinal cord injury program shall have either two years experience in the medical care of persons with spinal cord injuries or six months minimum in a spinal cord injury fellowship.
(5) The facility shall provide continuing education in the care and treatment of spinal cord injury patients for all staff.
(6) The facility shall provide specific staff training and education in the care and treatment of spinal cord injury.
(7) The size of the spinal cord injury program shall be adequate to support a comprehensive, dedicated ongoing spinal cord injury program.

History Note: *Authority G.S. 131E-104;*
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .3032 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13D .3033 DEEMED STATUS FOR INPATIENT REHABILITATION FACILITIES OR UNITS

History Note: *Authority G.S. 131E-104;*
Eff. January 1, 1996;
Repealed Eff. January 1, 2013.

SECTION .3100 - DESIGN AND CONSTRUCTION

10A NCAC 13D .3101 GENERAL RULES

(a) Each facility shall be planned, constructed, equipped, and maintained to provide the services offered in the facility.

(b) A new facility or remodeling of an existing facility shall meet the requirements of the North Carolina State Building Codes which are incorporated by reference, including all subsequent amendments. Copies of these codes may be purchased from the International Code Council online at http://www.iccsafe.org/Store/Pages/default.aspx at a cost of five hundred twenty-seven dollars ($527.00) or accessed electronically free of charge at http://www.ecodes.biz/ecodes_support/Free_Resources/2012NorthCarolina/12NorthCarolina_main.html. Existing licensed facilities shall meet the requirements of the North Carolina State Building Codes in effect at the time of construction or remodeling.

(c) Any existing building converted from another use to a nursing facility shall meet all requirements of a new facility.

(d) The sanitation, water supply, sewage disposal, and dietary facilities shall comply with the rules of the North Carolina Division of Public Health, Environmental Health Services Section, which are incorporated by reference, including all subsequent amendments. The "Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions", 15A NCAC 18A .1300 are available for inspection at the North Carolina Department of Health and Human Services, Division of Public Health, Environmental Health Services Section 5605 Six Forks Road, Raleigh, North Carolina 27509.
Copies may be obtained from the Environmental Health Services Section, 1632 Mail Service Center, Raleigh, NC 27699-1632 at no. cost, or can accessed electronically free of charge at http://reports.oah.state.nc.us/ncac.asp?folderName=\Title 15A - Environment and Natural Resources\Chapter 18 - Environmental Health.

(e) The adult care home portion of a combination facility shall meet the rules for a nursing facility contained in Sections .3100, .3200, and .3400 of this Subchapter, except when separated by two-hour fire resistive construction. When separated by two-hour fire-resistive construction, the adult care home portion of the facility shall meet the rules for adult care homes in 10A NCAC 13F, Licensing of Adult Care Homes, which are incorporated by reference, including all subsequent amendments; and adult care home resident areas must be located in the adult care home section of the facility. Copies of 10A NCAC 13F can be obtained free of charge from the Division of Health Service Regulation, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708, or accessed electronically free of charge at http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2013%20-%20nc%20medical%20care%20commission/subchapter%20d/subchapter%20d%20rules.html.

(f) An addition to an existing facility shall meet the same requirements as a new facility.

History Note: *Authority G.S. 131E-102; 131E-104;*
Eff. January 1, 1996;
Amended Eff. July 1, 2014;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .3102 APPLICATION OF PHYSICAL PLANT REQUIREMENTS

The physical plant requirements for each facility shall be applied as follows:

(1) New construction shall comply with the requirements of Sections .3100-.3400 of this Subchapter.

(2) Except where otherwise specified, existing buildings shall meet licensure and code requirements in effect at the time of construction, alteration or modification.

(3) New additions, alterations, modifications and repairs shall meet the technical requirements of Sections .3100-.3400 of this Subchapter; however, where strict conformance with current requirements would be impractical, the Division may approve alternative measures where the facility can demonstrate to the Division's satisfaction that the alternative measures do not reduce the safety or operating effectiveness of the facility.

(4) Rules contained in Sections .3100-.3400 of this Subchapter are minimum requirements and are not intended to prohibit buildings, systems or operational conditions that exceed minimum requirements.

(5) Equivalency: Alternate methods, procedures, design criteria and functional variations from the physical plant requirements, because of extraordinary circumstances, new programs or unusual conditions, may be approved by the Division when the facility can effectively demonstrate to the Division's satisfaction, that the intent of the physical plant requirements are met and that the variation does not reduce the safety or operational effectiveness of the facility.

(6) Where rules, codes or standards have any conflict, the most stringent requirement shall apply.

History Note: *Authority G.S. 131E-104;*
Eff. January 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .3103 SITE

The site of a proposed facility must be approved by the Department prior to construction as:

(1) accessible by public roads;
(2) accessible to fire fighting services;
(3) having a water supply, sewage disposal system, garbage disposal system, and trash disposal system approved by the local health department having jurisdiction;
(4) meeting all local ordinances and zoning laws; and
(5) being free from exposure to hazards and pollutants.

History Note: *Authority G.S. 131E-102; 131E-104;*
Eff. January 1, 1996;
Amended Eff. July 1, 2014;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .3104 PLANS AND SPECIFICATIONS

(a) When construction or remodeling of a facility is planned, one copy of construction documents and specifications shall be submitted by the owner or owner's appointed representative to the Department for review and approval. As a preliminary step to avoid last minute difficulty with construction documents approval, schematic design drawings and design development drawings may be submitted for approval prior to the required submission of construction documents.

(b) Approval of construction documents and specifications shall be obtained from the Department prior to licensure. Approval of construction documents and specifications shall expire one year after the date of approval unless a building permit for the construction has been obtained prior to the expiration date of the approval of construction documents and specifications.

(c) If an approval expires, renewed approval shall be issued by the Department, provided revised construction documents and specifications meeting the standards established in Sections .3100, .3200, and .3400 of this Subchapter are submitted by the owner or owner's appointed representative and reviewed by the Department.

(d) Any changes made during construction shall require the approval of the Department in order to maintain compliance with the standards established in Sections .3100, .3200, and .3400 of this Subchapter.

(e) Completed construction or remodeling shall conform to the standards established in Sections .3100, .3200, and .3400 of this Subchapter. Construction documents and building construction including the operation of all building systems shall be approved in writing by the Department prior to licensure or patient and resident occupancy.

(f) The owner or owner's appointed representative shall notify the Department in writing either by U.S. Mail or e-mail when actual construction or remodeling is complete.

History Note: Authority G.S. 131E-102; 131E-104;
Eff. January 1, 1996;
Amended Eff. July 1, 2014;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

SECTION .3200 - FUNCTIONAL REQUIREMENTS

10A NCAC 13D .3201 REQUIRED SPACES

(a) A facility shall meet the following requirements for bedrooms:
- (1) single bedrooms shall be provided with not less than 100 square feet of floor area;
- (2) bedrooms with more than one bed shall be provided with not less than 80 square feet of floor area per bed;
- (3) bedrooms shall have windows with views to the outdoors. The gross window area shall not be less than eight percent of the bedroom floor area required by Subparagraphs (1) and (2) of this Paragraph;
- (4) each bedroom shall be provided with one closet or wardrobe per bed. In nursing facilities and the nursing home portion of combination facilities, the closet or wardrobe shall have clothing storage space of not less than 36 cubic feet per bed with one-half of this space for hanging clothes. In the adult care home portion of a combination facility, the closet or wardrobe shall have clothing storage space of not less than 48 cubic feet per bed with one-half of this space for hanging clothes; and
- (5) floor space for closets, toilet rooms, vestibules, or wardrobes shall not be included in the areas required by this Subparagraph.

(b) A facility shall meet the following requirements for dining, activity, and common use areas:
- (1) nursing facilities and the nursing home portion of combination facilities shall have:
  - (A) a separate area or areas set aside for dining, measuring not less than 10 square feet per bed;
  - (B) a separate area or areas set aside for activities, measuring not less than 10 square feet per bed; and
  - (C) an additional dining, activity and common use area or areas, measuring not less than five square feet per bed. This area may be in a separate area or combined with the separate dining and activity areas required by Part (A) and (B) of this Subparagraph.
- (2) the adult care home portion of combination facilities shall have:
  - (A) a separate area or areas set aside for dining, measuring not less than 14 square feet per bed; and
  - (B) a separate area or areas set aside for activities, measuring not less than 16 square feet per bed.
- (3) the dining room area or areas required by this Paragraph may be combined.
- (4) the activity area or areas in nursing facilities and the nursing home portion of combination facilities shall not be combined with the activity area or areas in the adult care home portion of combination facilities.
- (5) floor space for physical, occupational, and rehabilitation therapy shall not be included in the areas required by this Paragraph. Closets and storage units for equipment and supplies shall not be included in the areas required by this Paragraph.
- (6) dining, activity, and common use areas shall be designed and equipped to provide accessibility to both patients and residents confined to wheelchairs and ambulatory patients or residents.
- (7) dining, activity, and common use areas required by this Paragraph shall have windows with views to the outdoors. The gross window area shall not be less than eight percent of the required floor area required by Subparagraphs (1) and (2) of this Paragraph.
- (8) for facilities designed with household units for 30 or fewer patients or residents, the dining and activity areas may be combined.

(c) Outdoor areas for individual and group activities shall be provided and shall be accessible to patients and residents with physical disabilities. In the adult care portion of a combination facility, a nursing unit with a control mechanism and staff procedures as required by Rule .3404(f) of this Subchapter shall have direct access to an outdoor area.

(d) Some means for patients and residents to lock personal articles within the facility shall be provided.
(e) A facility shall meet the following requirements for toilet rooms, tubs, showers, and central bathing areas:
- (1) a toilet room shall contain a toilet and lavatory. If a lavatory is provided in each bedroom, the toilet room is not required to have a lavatory.
- (2) a toilet room shall be accessible from each bedroom without going through the general corridor.
- (3) one toilet room may serve two bedrooms, but not more than eight beds.
- (4) one tub or shower shall be provided for each 15 beds not individually served by a tub or shower.
- (5) for each 120 beds or fraction thereof, a central bathing area shall be provided with the following:
  - (A) a bathtub or a manufactured walk-in bathtub or a similar manufactured bathtub designed for easy transfer of patients and residents into the tub. Bathtubs shall be accessible on three sides. Manufactured walk-in bathtubs or a similar manufactured bathtubs shall be accessible on two sides;
  - (B) a roll-in shower designed and equipped for unobstructed ease of shower chair entry and use. If a bathroom with a roll-in shower designed and equipped for unobstructed ease of shower chair entry adjoins each bedroom in the facility, the central bathing area is not required to have a roll-in shower;
  - (C) a toilet and lavatory; and
  - (D) a cubicle curtain enclosing the toilet, tub, and shower. A closed cubicle curtain at one of these plumbing fixtures shall not restrict access to the other plumbing fixtures.

(f) For each nursing unit, or fraction thereof on each floor, the following shall be provided:
- (1) a medication preparation area with:
  - (A) a counter;
  - (B) a double locked narcotic storage area under the visual control of nursing staff;
  - (C) a medication refrigerator;
  - (D) eye-level medication storage;
  - (E) cabinet storage; and
  - (F) a sink. The sink shall be trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four and one half inches in length. The sink water spout shall be mounted so that its discharge point is a minimum of 10 inches above the bottom of the sink basin;
- (2) a clean utility room with:
  - (A) a counter;
  - (B) storage; and
  - (C) a sink. The sink shall be trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four and one half inches in length. The sink water spout shall be mounted so that its discharge point is a minimum of 10 inches above the bottom of the sink basin;
- (3) a soiled utility room with:
  - (A) a counter;
  - (B) storage; and
  - (C) a sink. The sink shall be trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four and one half inches in length. The sink water spout shall be mounted so that its discharge point is a minimum of 10 inches above the bottom of the sink basin. The soiled utility room shall be equipped for the cleaning and sanitizing of bedpans as required by 15A NCAC 18A .1312 Toilet: Handwashing: Laundry: And Bathing Facilities;
- (4) a nurses' toilet and locker space for personal belongings;
- (5) a soiled linen storage room. If the soiled linen storage room is combined with the soiled utility room, a separate soiled linen storage room is not required;
- (6) clean linen storage provided in one or more of the following:
  - (A) a separate linen storage room;
  - (B) cabinets in the clean utility room; or
  - (C) a linen closet;
- (7) a nourishment station in an area enclosed with walls and doors with:
  - (A) work space;
  - (B) cabinets;

(C) refrigerated storage; and
(D) a small stove, microwave, or hot plate;
(8) an audio-visual nurse-patient call system arranged to ensure that a patient's or resident's call in the facility notifies and directs staff to the location where the call was activated;
(9) a control point located no more than 150 feet from the furthest patient or resident bedroom door with:
(A) an area for charting patient and resident records;
(B) space for storage of emergency equipment and supplies; and
(C) nurse patient call and alarm annunciation systems; and
(10) a janitor's closet.

(g) If a facility is designed with patient or resident household units, a patient and resident dietary area located within the patient or resident household unit may substitute for the nourishment station. The patient or resident dietary area shall be for the use of staff, patients, residents, and families. The patient or resident dietary area shall contain:
(1) cooking equipment;
(2) a kitchen sink;
(3) refrigerated storage; and
(4) storage areas.

(h) Clean linen storage shall be provided in a separate room from bulk supplies.

(i) The kitchen area and laundry area each shall have a janitor's closet. Administration, occupational and physical therapy, recreation, personal care, and employee areas shall be provided janitor's closets and may share one as a group.

(j) Stretcher and wheelchair storage shall be provided.

(k) The facility shall provide patient and resident storage at the rate of not less than five square feet of floor area per licensed bed. This storage space shall:
(1) be used by patients and residents to store out-of-season clothing and suitcases;
(2) be either in the facility or within 500 feet of the facility on the same site; and
(3) be in addition to the other storage space required by this Rule.

(l) Office space shall be provided for business transactions. Office space shall be provided for persons holding the following positions:
(1) administrator;
(2) director of nursing;
(3) social services director;
(4) activities director; and
(5) physical therapist.

(m) Each combination facility shall provide a minimum of one residential washer and residential dryer in a location accessible by adult care home staff, residents, and residents' families.

History Note: Authority G.S. 131E-104; 42 CFR 483.70;
Eff. January 1, 1996;
Amended Eff. August 1, 2014; October 1, 2008;
Readopted Eff. July 1, 2016;
Amended Eff. October 1, 2016.

10A NCAC 13D .3202 FURNISHINGS

(a) A facility shall provide handgrips at all toilet and bath facilities used by residents. Handrails shall be provided on both sides of all corridors where corridors are defined by walls and used by residents.

(b) A facility shall provide flame resistant privacy screens or curtains in multi-bedded rooms.

History Note: Authority G.S. 131E-102; 131E-104;
Eff. January 1, 1996;
Amended Eff. July 1, 2014;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

SECTION .3300 - FIRE AND SAFETY REQUIREMENTS

10A NCAC 13D .3301 NEW FACILITY REQUIREMENTS
10A NCAC 13D .3302 ADDITIONS

History Note: Authority G.S. 131E-102; 131E-104;
Eff. January 1, 1996;
Repealed Eff. July 1, 2014.

SECTION .3400 - MECHANICAL: ELECTRICAL: PLUMBING

10A NCAC 13D .3401 HEATING AND AIR CONDITIONING

(a) A facility shall provide heating and cooling systems complying with the following:

(1) The American National Standards Institute and American Society of Heating, Refrigerating, and Air Conditioning Engineers Standard 170: Ventilation of Health Care Facilities, which is incorporated by reference, including all subsequent amendments and editions, and may be purchased for a cost of fifty-four dollars ($54.00) online at http://www.techstreet.com/ashrae/lists/ashrae_standards.tmpl.
This incorporation does not apply to Section 7.1, Table 7-1 Design Temperature for Skilled Nursing Facility. The environmental temperature control systems shall be capable of maintaining temperatures in the facility at 71 degrees F. minimum in the heating season and a maximum of 81 degrees F. during the non-heating season; and

(2) The National Fire Protection Association 90A: Standard for the Installation of Air-Conditioning and Ventilating Systems, which is incorporated by reference, including all subsequent amendments and editions, and may be purchased at a cost of thirty-nine dollars ($39.00) from the National Fire Protection Association online at http://www.nfpa.org/catalog/ or accessed electronically free of charge at http://www.nfpa.org/aboutthecodes/AboutTheCodes.asp?DocNum=90A.

(b) In a facility, the windows in dining, activity and living spaces, and bedrooms shall be openable from the inside. To inhibit patient and resident elopement from any window, the facility may restrict the window opening to a six-inch opening.

History Note: Authority G.S. 131E-102; 131E-104;
Eff. January 1, 1996;
Amended Eff. July 1, 2014;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .3402 EMERGENCY ELECTRICAL SERVICE

A facility shall provide an emergency electrical service for use in the event of failure of the normal electrical service. This emergency electrical service shall consist of the following:

(1) In any existing facility:
   (a) type 1 or 2 emergency lights as required by the North Carolina State Building Codes: Electrical Code;
   (b) additional emergency lights for all control points required by Rule .3201(l)(9) of this Subchapter, medication preparation areas required by Rule .3201(l)(1) of this Subchapter and storage areas, and for the telephone switchboard, if applicable;
   (c) one or more portable battery-powered lamps at each control point required by Rule .3201(l)(9) of this Subchapter; and
   (d) a source of emergency power for life-sustaining equipment, if the facility admits or cares for occupants needing such equipment, to ensure continuous operation with on-site fuel storage for a minimum of 72 hours.

(2) An emergency power generating set, including the prime mover and generator, shall be located on the premises and shall be reserved exclusively for supplying the essential electrical system. For the purposes of this Rule, the "essential electrical system" means a system comprised of alternate sources of power and all connected distribution systems and ancillary equipment, designed to ensure continuity of electrical power to designated areas and functions of a facility during

disruption of normal power sources, and also to minimize disruption within the internal wiring system as defined by the North Carolina State Building Codes: Electrical Code.

(3) Emergency electrical services shall be provided as required by Rule .3101(b) of this Subchapter with the following modification: Section 517.10(B)(2) of the North Carolina State Building Codes: Electrical Code shall not apply to new facilities.

(4) The following equipment, devices, and systems which are essential to life safety and the protection of important equipment or vital materials shall be connected to the critical branch of the essential electrical system as follows:
   (a) nurses' calling system;
   (b) fire pump, if installed;
   (c) one elevator, where elevators are used for the transportation of patients;
   (d) equipment such as burners and pumps necessary for operation of one or more boilers and their necessary auxiliaries and controls, required for heating and sterilization, if installed;
   (e) equipment necessary for maintaining telephone service; and
   (f) task illumination of boiler rooms, if applicable.

(5) A dedicated critical branch circuit per bed for ventilator-dependent patients is required. This critical branch circuit shall be provided with two duplex receptacles identified for emergency use. When staff determines that the electrical life support needs of the patient exceed the requirements stated in this Item, additional critical branch circuits and receptacles shall be provided. For the purposes of this Rule, a "critical branch circuit" is a circuit of the critical branch subsystem of the essential electrical system which supplies energy to task lighting, selected receptacles and special power circuits serving patient care areas as defined by the North Carolina State Building Codes: Electrical Code. This Item applies to both new and existing facilities.

(6) Heating equipment provided for ventilator dependent patient bedrooms shall be connected to the critical branch of the essential electrical system and arranged for delayed automatic or manual connection to the emergency power source if the heating equipment depends upon electricity for proper operation. This Item applies to both new and existing facilities.

(7) Task lighting connected to the automatically transferred critical branch of the essential electrical system shall be provided for each ventilator dependent patient bedroom. For the purposes of this Item, task lighting is defined as lighting needed to carry out necessary tasks for the care of a ventilator dependent patient. This Item applies to both new and existing facilities.

(8) Where electricity is the only source of power normally used for the heating of space, an essential electrical system shall provide for heating of patient rooms. Emergency heating of patient rooms shall not be required in areas where the facility is supplied by at least two separate generating sources or a network distribution system with the facility feeders so routed, connected, and protected that a fault any place between the generating sources and the facility will not cause an interruption of more than one of the facility service feeders.

(9) An essential electrical system shall be so controlled that after interruption of the normal electric power supply, the generator is brought to full voltage and frequency and connected within 10 seconds through one or more primary automatic transfer switches to all emergency lighting, alarms, nurses' call, and equipment necessary for maintaining telephone service. All other lighting and equipment required to be connected to the essential electrical system shall either be connected through the 10 second primary automatic transfer switching or shall be connected through delayed automatic or manual transfer switching. If manual transfer switching is provided, staff of the facility shall operate the manual transfer switch.

(10) Sufficient fuel shall be stored for the operation of the emergency power generator for a period not less than 72 hours, on a 24-hour per day operational basis with on-site fuel storage. The generator system shall be tested and maintained per National Fire Protection Association Health Care Facilities Code, NFPA 99, which is incorporated by reference, including all subsequent amendments and editions. Copies of this code may be obtained from the National Fire Protection Association - online at http://www.nfpa.org/catalog/ or accessed electronically free of charge at http://www.nfpa.org/aboutthecodes/AboutTheCodes.asp?DocNum=99. The facility shall maintain records of the generator system tests and shall make these records available to the Department for inspection upon request.

(11) The electrical emergency service at existing facilities shall comply with the requirements established in Sections .3100, and .3400 of this Subchapter in effect at the time a license is first

issued. Any remodeling of an existing facility that results in changes to the emergency electrical service shall comply with the requirements established in Sections .3100, and .3400 of this Subchapter in effect at the time of remodeling.

History Note: *Authority G.S. 131E-102; 131E-104;*
Eff. January 1, 1996;
Amended Eff. July 1, 2014;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .3403 GENERAL ELECTRICAL

(a) In a facility, all main water supply shut off valves in the sprinkler system shall be electronically supervised so that if any valve is closed an alarm will sound at a central station manned 24 hours per day, seven days per week.
(b) No two adjacent emergency lighting fixtures shall be on the same circuit.
(c) Receptacles in bathrooms shall have ground fault protection.
(d) Each patient bed location shall be provided with a minimum of four single or two duplex receptacles. Two single receptacles or one duplex receptacle shall be connected to the critical branch of the emergency power system at each bed location. Each patient bed location shall also be provided with a minimum of two single receptacles or one duplex receptacle connected to the normal electrical system.
(e) Each patient bed location shall be supplied by at least two branch circuits.
(f) The fire alarm system shall be installed to transmit an alarm automatically to the fire department that is legally committed to serve the area in which the facility is located. The alarm shall be transmitted either to a fire department or to a third-party service that shall transmit the alarm to the fire department. The method used to transmit the alarm shall be approved by local ordinances.
(g) In patient areas, fire alarms shall be gongs or chimes rather than horns or bells.

History Note: *Authority G.S. 131E-102; 131E-104;*
Eff. January 1, 1996;
Amended Eff. July 1, 2014;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

10A NCAC 13D .3404 OTHER

(a) In general patient areas of a facility, each room shall be served by at least one calling station and each bed shall be provided with a call button. Two call buttons serving adjacent beds may be served by one calling station. Calls shall register with the floor staff and shall activate a visible signal in the corridor at the patient's or resident's door. On multi-corridor nursing units, additional visible signals shall be installed at corridor intersections. In rooms containing two or more calling stations, indicating lights shall be provided at each station. Nurses' calling systems that provide two-way voice communication shall be equipped with an indicating light at each calling station that lights and remains lighted as long as the voice circuit is operating. A nurses' call emergency button shall be provided for patients' and residents' use at each patient and resident toilet, bath, and shower.
(b) A facility shall provide:
  (1) at least one telephone located to be accessible by patients, residents, and families for making local phone calls; and
  (2) cordless telephones or telephone jacks in patient and resident rooms to allow access to a telephone by patients and residents when needed.
(c) Outdoor lighting shall be provided to illuminate walkways and drives.
(d) A flow of hot water shall be within safety ranges specified as follows:
  (1) Patient Areas - 6 1/2 gallons per hour per bed and at a temperature of 100 to 116 degrees F;
  (2) Dietary Services - 4 gallons per hour per bed and at a minimum temperature of 140 degrees F; and
  (3) Laundry Area - 4 1/2 gallons per hour per bed and at a minimum temperature of 140 degrees F.
(e) If provided in a facility, medical gas and vacuum systems shall be installed, tested, and maintained in accordance with the National Fire Protection Association Health Care Facilities Code, NFPA 99, which is incorporated by reference, including all subsequent amendments and editions. Copies of this code may be purchased for a cost of sixty-one dollars ($61.50) from the National Fire Protection Association online at

http://www.nfpa.org/catalog/ or accessed electronically free of charge at http://www.nfpa.org/aboutthecodes/AboutTheCodes.asp?DocNum=99.

(f) Each facility shall have a control mechanism and staff procedures for monitoring and managing patients who wander or are disoriented. The control mechanism shall include egress alarms and any of the following:

(1) an electronic locking system;
(2) manual locks; and
(3) staff supervision.

This requirement applies to new and existing facilities.

(g) Sections of the National Fire Protection Association Life Safety Code, NFPA 101, 2012 edition listed in this Paragraph are adopted by reference.

(1) 18.2.3.4 with requirements for projections into the means of egress corridor width of wheeled equipment and fixed furniture;
(2) 18.3.2.5 with requirements for the installation of cook tops, ovens and ranges in rooms and areas open to the corridors;
(3) 18.5.2.3(2), (3) and (4) with requirements for the installation of direct-vent gas and solid fuel-burning fireplaces in smoke compartments; and
(4) 18.7.5.6 with requirements for the installation of combustible decorations on walls, doors and ceilings.

Smoke compartments where the requirements of these Sections are applied must be protected throughout by an approved automatic sprinkler system. For the purposes of this Rule, "smoke compartments" are spaces within a building enclosed by smoke barriers on all sides, including the top and bottom as indicated in NFPA 101, 2012 edition. Where these Sections are less stringent than requirements of the North Carolina State Building Codes, the requirements of the North Carolina State Building Codes shall apply. Where these Sections are more stringent than the North Carolina State Building Codes, the requirements of these Sections shall apply. Copies of this code may be purchased for a cost of ninety-three dollars ($93.00) from the National Fire Protection Association online at http://www.nfpa.org/catalog/ or accessed electronically free of charge at http://www.nfpa.org/aboutthecodes/AboutTheCodes.asp?DocNum=101.

(h) Ovens, ranges, cook tops, and hot plates located in rooms or areas accessible by patients or residents shall not be used by patients or residents except under facility staff supervision. The degree of staff supervision shall be based on the facility's assessment of the capabilities of each patient and resident.

History Note: *Authority G.S. 131E-102; 131E-104;*
Eff. January 1, 1996;
Amended Eff. July 1, 2014;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

SUBCHAPTER 13E – LICENSING OF OVERNIGHT RESPITE SERVICES

SECTION .0100 DEFINITIONS

10A NCAC 13E .0101 DEFINITIONS

The following definitions apply throughout this Subchapter:

(1) "Accident" means an unexpected, unintentional, or irregular event that results in injury or illness to a participant or suspected injury or illness to a participant.
(2) "Overnight respite services" is defined in G.S. 131D-6.1 and shall not exceed 14 consecutive days or more than 60 total calendar days per individual participant in a 365-day period.
(3) "Participant" means the recipient of the overnight respite services.
(4) "Personal care" means tasks such as assistance with bathing, dressing, grooming, toileting, eating, ambulation, and transferring.
(5) "Program" means a facility certified by the Department of Health and Human Services, Division of Aging and Adult Services, to provide adult day care services pursuant to G.S. 131D-6 and 10A NCAC 06R, adult day health services pursuant to 10A NCAC 06S, or both.
(6) "Responsible party" means the caretaker with primary day-to-day responsibility for a participant.

(7) "Supervision" means to oversee, manage, and direct for the determination and provision of assistance to a participant.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

SECTION .0200 – LICENSING

10A NCAC 13E .0201 APPLYING FOR A LICENSE TO PROVIDE OVERNIGHT RESPITE SERVICES

(a) Except as otherwise provided in Rule .0202 of this Section, the Division of Health Service Regulation (DHSR) shall issue an overnight respite services license to any program that meets the following requirements:

(1) submission of an initial license application, available at https://info.ncdhhs.gov/dhsr/acls/acforms.html at no cost that includes the following:
    (A) applicant information;
    (B) ownership information; and
    (C) the program's capacity and scope of services;
(2) payment of the non-refundable license fee required by G.S. 131D-6.1; and
(3) compliance with the provisions of G.S. 131D-6.1 and the rules of this Subchapter.

(b) An application for a license to provide overnight respite services shall not be reviewed or approved unless the applicant is certified by the Division of Aging and Adult Services as a program as defined in Rule .0101 of this Subchapter.

(c) Following review of the initial license application, program policies in accordance with Rule .0501 of this Subchapter, and the Construction Section's recommendation for use, a pre-approval visit shall be made by the DHSR Adult Care Licensure Section or its consultant. The Adult Care Licensure Section shall notify, in writing, the Division of Aging and Adult Services and the applicant of the decision to approve or deny a license to provide overnight respite services as a part of the adult day care program.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017;
Amended September 1, 2019.

10A NCAC 13E .0202 PERSONS NOT ELIGIBLE FOR OVERNIGHT RESPITE SERVICES LICENSES

A license for an overnight respite services program shall not be issued to an applicant:

(1) whose license for any overnight respite services program was revoked until one year after the date of revocation; or
(2) whose admissions for any overnight respite services program were suspended until six months after the suspension is lifted.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0203 THE LICENSE

(a) The license shall be posted in a prominent location, accessible to public view, within the overnight respite portion of the facility.

(b) The license shall be in effect for 12 months from the date of issuance unless revoked for cause or voluntarily or involuntarily terminated.

(c) The license is not transferable or assignable.

(d) The license shall be terminated when the program is terminated.

History Note: Authority G.S. 131D-2.4; 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0204 RENEWAL OF LICENSE

(a) The license shall be renewed annually, except as otherwise provided in Rule .0205 of this Section, if the licensee submits an application for renewal and the Department determines that the licensee complies with the provisions of

G.S. 131D-6.1 and the rules of this Subchapter. When violations of the rules of this Subchapter are documented and have not been corrected prior to expiration of the license, the Department may approve an extension of a plan of correction or may revoke the license for cause.
(b) In determining whether to renew a license under G.S. 131D-6.1 or extend a plan of correction, the Department shall take into consideration the following factors:

(1) the compliance history of the adult day care program;
(2) the compliance history of overnight respite services;
(3) the extent to which the conduct of a related licensed program for overnight respite services is likely to affect the quality of care at the applicant service; and
(4) the hardship on residents of the applicant service if the license is not renewed.

(c) The license renewal application shall be sent to the applicant by the Department at least 60 days prior to expiration of the license.
(d) The license renewal application shall include the following:

(1) applicant information;
(2) ownership information;
(3) the program's capacity and scope of services; and
(4) invoice for the annual nonrefundable renewal licensure fee in accordance with G.S. 131D-6.1(i).

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0205 CLOSING OF OVERNIGHT RESPITE SERVICES
If a licensee plans to close its overnight respite services, the licensee shall provide written notification of the planned closing to the Division of Health Service Regulation, Adult Care Licensure Section at 2708 Mail Service Center, Raleigh, NC 27699-2708; the Division of Aging and Adult Services at 2101 Mail Service Center, Raleigh, NC 27699-2101; and the participants and their responsible parties at least 30 days prior to the planned closing. Written notification shall include the date of closing.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0206 DENIAL AND REVOCATION OF LICENSE
(a) The Division of Health Service Regulation shall deny any licensure application if the applicant fails to comply with G.S. 131D-6.1 and the rules of this Subchapter.
(b) A license may be revoked by the Division in accordance with G.S. 131D-2.7 and G.S. 131D-6.1.
(c) The Division shall notify the applicant of a denial of its application or revocation of its license by certified mail stating the reasons for the denial or revocation.
(d) When an overnight respite service provider receives a notice of revocation, the administrator shall inform each participant and the participant's responsible party of the notice and the reasons for the revocation.

History Note: Authority G.S. 131D-2.7; 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0207 SUSPENSION OF ADMISSIONS
(a) The Division of Health Service Regulation may suspend the admission of participants to overnight respite services when warranted under the provisions of G.S. 131D-6.1 and G.S. 131D-2.7.
(b) The Division shall notify the overnight respite service licensee by certified mail of the decision to suspend admissions. Such notice shall include:

(1) the period of the suspension;
(2) factual allegations;
(3) citation of statutes and rules alleged to be violated; and
(4) notice of the licensee's right to a contested case hearing regarding the suspension.

(c) The suspension shall be effective on the date specified in the notice of suspension. The suspension shall remain effective for the period specified in the notice or until the overnight respite service demonstrates to the Division that conditions are no longer detrimental to the health and safety of the participants based on the factors set forth in G.S. 131D-2.7(d)(2).

(d) The overnight respite service shall not admit any participants during the effective period of the suspension.
(e) Any action taken by the Division to revoke a license for overnight respite services shall be accompanied by a suspension of admissions.

History Note: *Authority G.S. 131D-2.7; 131D-6.1;*
Eff. April 1, 2017.

10A NCAC 13E .0208 APPEAL OF LICENSURE ACTION
The licensee may appeal any decision of the Division to deny or revoke a license or any decision to suspend admissions of participants by making such an appeal in accordance with G.S. 150B.

History Note: *G.S. 131D-6.1;*
Eff. April 1, 2017.

SECTION .0300 - PHYSICAL PLANT RULES

10A NCAC 13E .0301 SUBMISSION OF INFORMATION TO THE DIVISION OF HEALTH SERVICE REGULATION CONSTRUCTION SECTION
(a) Prior to operation, an applicant for a license to provide overnight respite services shall submit the following documents to the Division of Health Service Regulation (DHSR) Construction Section:
- (1) an approval letter from the local zoning jurisdiction for the proposed location;
- (2) if an existing structure, a photograph of each side of the existing structure and at least one of each of the interior spaces; and
- (3) a set of building plans of each floor level indicating:
  - (A) the layout of all rooms;
  - (B) room dimensions (including closets);
  - (C) door widths (exterior, bedroom, bathroom, and kitchen doors);
  - (D) window sizes and window sill heights;
  - (E) type of construction; and
  - (F) the proposed participant bedroom locations including the number of occupants in each bedroom.

(b) The Construction Section shall review the documents and notify the applicant by letter of changes that shall be made to the building to meet the standards established in this Section. The letter shall also contain a list of final documentation required from the local fire marshal, local building code official, and county health department that shall be submitted upon completion of any required changes to the building or completion of construction.
(c) In order to maintain compliance with the standards established in this Section, any changes made during construction that were not proposed during the document review required by Paragraph (b) of this Rule shall require the approval of the Construction Section.
(d) Upon receipt of the final documentation required by Paragraph (b) of this Rule, the Construction Section shall review the information and may either approve the overnight respite services program for construction based on documentation or make an on-site visit. If an on-site visit is made, the Construction Section shall inspect the construction and shall notify the applicant by letter of any changes that shall be made to the construction. When the Construction Section determines that the completed construction is in compliance with the standards established in this Section, it shall notify the Division of Health Service Regulation Adult Care Licensure Section of its recommendation for use.

History Note: *Authority G.S. 131D-6.1;*
Eff. April 1. 2017.

10A NCAC 13E .0302 CAPACITY
(a) Pursuant to G.S. 131D-6.1(c)(8), the Division of Health Service Regulation shall not approve a capacity of greater than six participants for an overnight respite services program. For the purposes of this Rule, "capacity" means the maximum number of participants that the overnight respite services program is licensed to house at any given time.
(b) An overnight respite services program shall not exceed the capacity shown on its license.

(c) Prior to an increase in capacity by adding rooms, altering rooms, or changing use of space, the overnight respite services program shall submit a request for capacity increase and two building plans of each floor to the Construction Section. One plan shall indicate the current use of rooms in the existing building. The other plan shall indicate the proposed use of rooms in the existing building and its addition, alteration, or change in use of space. For an addition to an existing building, the building plans shall also indicate how the addition will be tied into the existing building and any proposed changes to the building structure.
(d) When the overnight respite services program increases its capacity by the addition to or alteration of an existing building, the entire overnight respite services program shall comply with the North Carolina Fire Prevention Code, which is incorporated herein by reference including subsequent amendments and editions. Copies of this code may be purchased from the International Code Council online at http://www.iccsafe.org/Store/Pages/default.aspx at a cost of eighty-five dollars ($85.00) or accessed electronically free of charge at http://codes.iccsafe.org/app/book/toc/2012/North_Carolina/Fire/index.html.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0303 DESIGN AND CONSTRUCTION
(a) For the purposes of this Rule the following definitions apply:
- (1) "facility" means a building or portion of a building housing an overnight respite services program as defined in G.S. 131D-6.1(a);
- (2) "proposed facility" means the new construction of a building for a facility, an addition or alteration to an existing building for a facility, or the change in use of a building for a facility;
- (3) "existing facility" means a currently licensed facility and a proposed facility that will be built according to building plans approved by the Construction Section for compliance with the standards established in this Section, prior to the effective date of this Rule; and
- (4) "new facility" means a proposed facility that will be built according to building plans approved by the Construction Section for compliance with the standards established in this Section, on or after the effective date of this Rule.

(b) The physical plant requirements for each facility shall be applied as follows:
- (1) A new facility shall meet the standards established in this Section.
- (2) An existing facility shall meet the standards established in this Section that were in existence at the time of change in use of space, construction, addition, alteration, or repair.
- (3) An existing building converted from another use that a program intends to use for an overnight respite services program shall meet all the requirements of a new facility as indicated in Subparagraph (1) of this Paragraph.

(c) All new construction, additions, or alterations for a new facility shall meet the requirements of the North Carolina State Building Codes, which are incorporated herein by reference including subsequent amendments and editions. Copies of these codes may be purchased from the International Code Council online at http://www.iccsafe.org/Store/Pages/default.aspx at a cost of five hundred twenty-seven dollars ($527.00) or accessed electronically free of charge at http://codes.iccsafe.org/North%20Carolina.html. All new construction, additions, or repairs of an existing facility shall meet the requirements of the North Carolina State Building Codes in effect at the time of construction, addition, alteration, or repair.
(d) A facility shall be constructed, equipped, and maintained to comply with the standards established in this Section for the capacity indicated on its license.
(e) The Construction Section may grant an equivalency to allow an alternate design or functional variation from the requirements of the rules contained in this Section. For the purposes of this Rule, an "equivalency" is a Construction Section-approved alternate design and functional variation to a requirement contained in the rules of this Section that meets the intent of the rule requirement but does not reduce the safety and operational effectiveness of the facility design and layout. If granted, the equivalency shall apply to a specific facility. A program shall be granted an equivalency if:
- (1) the overnight respite services program submits a written equivalency request to the Construction Section indicating:
  - (A) the rule requirement that will not be met;
  - (B) the justification for the equivalency; and
  - (C) how the proposed equivalency meets the intent of the corresponding rule requirement; and

(2) the program receives a written approval of the equivalency from the Construction Section.

(f) If any of the rules, codes, or standards contained in this Section conflict, the most restrictive requirement shall apply.

(g) For an existing facility whose license is revoked or suspended by the Division of Health Service Regulation pursuant to G.S. 131D-6.1(g)(2) for at least 60 days, the facility shall meet the requirements of a new facility as required by Subparagraph (b)(1) of this Rule prior to being relicensed.

(h) Prior to commencement of construction or change in use of space, any program intending to offer overnight respite care services that is planning new construction, an addition or alteration to an existing building, or a change in use of space shall submit building plans and other documents to the Construction Section as specified in Rule .0301 of this Section.

(i) If the building to be used for a facility is two or more stories in height, it shall meet the following additional requirements:

(1) construction shall not exceed the allowable area for occupancy in the North Carolina State Building Code;

(2) participants shall be housed on the level of the principal exterior door as defined in Rule .0312(c) of this Section; and

(3) participant-use areas shall be located on the level of the principal exterior door.

(j) The basement and the attic shall not to be used for storage or sleeping.

(k) The ceiling shall be at least seven and one-half feet from the floor.

(l) Elevation changes in the floor are not permitted in participant-use areas.

(m) The door width shall be a minimum of two feet and six inches in the kitchen, dining room, living room, bedrooms, and bathrooms.

(n) Windows shall be operable and shall be maintained operable. For the purposes of this Rule, "operable" means a window that may be opened and shut to allow outdoor-air ventilation. To inhibit participant elopement from any window, the window opening may be restricted to a six-inch opening.

(o) Before starting any construction or alterations, the overnight respite services program shall consult with the local building code official for information about required permits and construction requirements.

(p) The facility shall comply with the sanitation rules of the North Carolina Division of Public Health, Environmental Health Services Section, which are incorporated herein by reference including subsequent amendments and editions. The "Rules Governing the Sanitation of Residential Care Facilities," 15A NCAC 18A .1600 are available for inspection at the North Carolina Department of Health and Human Services, Division of Public Health, Environmental Health Services Section, 5605 Six Forks Road, Raleigh, North Carolina 27609. Copies may be obtained from the Environmental Health Services Section, 1632 Mail Service Center, Raleigh, NC 27699-1632 at no cost or can be accessed electronically free of charge at http://ehs.ncpublichealth.com/docs/rules/294306-4-1600.pdf.

(q) The facility shall have the following inspection reports available for review upon request by the Construction Section:

(1) a current sanitation inspection report from the county health department; and

(2) a current fire safety inspection report from the local fire marshal.

(r) The building housing a facility shall be equipped with a fire alarm system with pull stations on each floor and sounding devices that are audible throughout the building. The fire alarm system shall be equipped to transmit an automatic signal to the local emergency fire department dispatch center, either directly or through a central station monitoring company connection. The fire alarm system shall be installed in accordance with National Fire Protection Association (NFPA) 72, which is incorporated herein by reference including subsequent amendments and editions and may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269 at the cost of ninety six dollars and 50 cents ($96.50). Underwriters Laboratory (U.L.) listed heat detectors are required in attics and basements and shall be connected to the fire alarm system. These heat detectors shall be interconnected and provided with battery backup. Corridors shall be equipped with smoke detectors that are connected to the fire alarm system.

(s) A building housing an overnight respite services program or an adult day care or adult health care program shall be equipped with a wet pipe sprinkler system in accordance with NFPA 13, which is incorporated herein by reference including subsequent amendments and editions and may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269 at the cost of one hundred and three dollars ($103.00).

History Note: *Authority G.S. 131D-6.1;*
Eff. April 1, 2017.

10A NCAC 13E .0304 LOCATION

(a) A program offering overnight respite care services shall be in a location approved by local zoning boards.

(b) The site of a proposed facility where overnight respite care services are to be provided shall:

(1) be accessible by public roads that shall be maintained for motor vehicles access;

(2) be accessible to fire fighting and other emergency services;

(3) have a water supply, sewage disposal system, garbage disposal system, and trash disposal system approved by the local health department having jurisdiction;

(4) comply with local ordinances; and

(5) be free from exposure to waste material that contaminates the air, soil, or water.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0305 LIVING ROOM

(a) Each overnight respite care program shall have a living area with not less than 40 square feet of floor area per participant.

(b) The living area for the overnight respite care program required by Paragraph (a) of this Rule may be combined with the adult day care program or adult day health program activities and craft areas only after the Division of Aging and Adult Services of the Department of Health and Human Services determines, in writing, that the requirements of 10A NCAC 06R .0401(d) for an adult day care program and 10A NCAC 06S .0301 for an adult day health program are met.

(c) The living room shall have windows with views to the outdoors. The gross window area shall not be less than eight percent of the floor area required by Paragraph (a) of this Rule.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0306 DINING ROOM

(a) Each overnight respite services program shall have a dining area with not less than 20 square feet of floor area per participant. The dining area may be used for other activities during the day.

(b) The dining area for the overnight respite care program required by Paragraph (a) of this Rule may be combined with the adult day care program or adult day health program activities and craft areas only after the Division of Aging and Adult Services of the Department of Health and Human Services determines, in writing, that the requirements of 10A NCAC 06R .0401(d) for an adult day care program and 10A NCAC 06S .0301 for an adult day health program are met.

(c) When the dining area is used in combination with a kitchen, an area five feet wide shall be allowed as work space between the kitchen and dining areas. The work space shall not be used as the dining area.

(d) The dining room shall have windows with views to the outdoors. The gross window area shall not be less than eight percent of the floor area required by Paragraph (a) of this Rule.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0307 KITCHEN

(a) The kitchen shall have a floor area of not less than 120 square feet. The kitchen may be shared with the adult day care or adult day health program.

(b) The cooking unit shall be mechanically ventilated to the exterior or be equipped with an unvented recirculation fan provided with a filter as required by the manufacturer's instructions for vent-less use.

(c) The kitchen floor shall have a non-slippery and water-resistant covering.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0308 BEDROOMS

(a) There shall be bedrooms sufficient in number and size to meet the individual needs of the participant according to their age and gender.
(b) A room used as a bedroom shall meet the requirements of this Rule and be approved by the Construction Section.
(c) A room accessed only through a bathroom, kitchen, or another bedroom shall not be approved for a participant's bedroom.
(d) Bedrooms occupied by one participant shall be provided with not less than 100 square feet of floor area, including vestibule, closet, or wardrobe space. Bedrooms occupied by two participants shall be provided with not less than 160 square feet of floor area, including vestibule, closet, or wardrobe space,
(e) The total number of participants assigned to a bedroom shall be based on the square footage requirements of Paragraph (d) of this Rule as approved by the Construction Section for that bedroom.
(f) A bedroom shall not be occupied by more than two participants.
(g) Each participant bedroom shall have one or more windows with views to the outdoors. The gross window area shall be equal to at least eight percent of the floor space required by Paragraph (d) of this Rule. The windows shall have a maximum sill height of 44 inches.
(h) Bedroom closets or wardrobes shall be large enough to provide each participant with a minimum of 22 cubic feet of clothing storage, one-half of which shall be for hanging clothes with an adjustable-height hanging bar.

History Note: *Authority G.S. 131D-6.1;*
Eff. April 1, 2017.

10A NCAC 13E .0309 BATHROOM

(a) An overnight respite services program shall have one bathroom for each six or fewer respite participants. A bathroom shall contain a toilet, a lavatory, and one of the following:
(1) a roll-in shower designed and equipped for unobstructed shower chair entry and use;
(2) a bathtub accessible on three sides; or
(3) a manufactured walk-in bathtub or a similar manufactured bathtub designed for transfer of participants into the bathtub that is accessible on one short side and one long side of the bathtub.
(b) The bathroom required by Paragraph (a) of this Rule may be shared with the adult day care program or adult day health program only after the Division of Aging and Adult Services of the Department of Health and Human Services determines, in writing, that the requirements of 10A NCAC 06R .0401(g) for an adult day care facility and 10A NCAC 06S .0301 for an adult day health facility are met.
(c) A bathroom shall be designed to provide privacy. A bathroom with two or more toilets shall have privacy partitions or curtains for each toilet. Each bathtub or shower shall have privacy partitions or curtains.
(d) The entrance to the bathroom shall not be through a kitchen, another participant's bedroom, or another bathroom.
(e) The bathroom shall be located so that there is no more than 40 feet between any participant's bedroom door and a participant-use bathroom door.
(f) Hand grips shall be installed at all toilets, bathtubs, and showers used by participants.
(g) Nonskid surfacing or strips shall be installed to the floor or bottom of showers and bathtubs.
(h) A bathroom shall have mechanical ventilation at the rate of two cubic feet per minute for each square foot of floor area. The mechanical ducted vent shall be vented directly to the outdoors.
(i) The bathroom floor shall have a non-slippery water-resistant covering.

History Note: *Authority G.S. 131D-6.1;*
Eff. April 1, 2017.

10A NCAC 13E .0310 STORAGE AREAS

(a) Storage areas shall be provided for the separate storage of clean linens, soiled linens, food and food service supplies, and household supplies and equipment.
(b) Cleaning agents, bleaches, pesticides, and other substances that may be hazardous if ingested, inhaled, or handled shall be stored in locked areas separate from other materials.

History Note: *Authority G.S. 131D-6.1;*
Eff. April 1, 2017.

10A NCAC 13E .0311 CORRIDOR
(a) Corridors shall be lighted as required by Rule .0317(e)(3) of this Section.
(b) Corridors shall be free of equipment and other obstructions.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0312 OUTSIDE ENTRANCE AND EXITS
(a) Each overnight respite services program shall have at least two exit doors on all floor levels. If there are only two exit doors, the exit doors shall be located and constructed to minimize the possibility that both may be blocked by a fire or other emergency condition.
(b) One exterior door shall have a minimum width of three feet. Another exterior door shall have a minimum width of two feet and eight inches. For the purposes of this Rule, an "exterior door" means a door used by a participant to enter and exit the building to and from the outdoors.
(c) At least one principal exterior door for the participants' use shall be at grade level or accessible by a ramp with a one inch rise for each 12 inches of ramp length. For the purposes of this Rule, a "principal exterior door" means a door that is used by participants to access the vehicular pick-up and drop-off area. If the overnight respite services program serves any participant who must have physical assistance with evacuation, the building shall have two exterior doors at grade level or accessible by a ramp.
(d) All exit door locks shall be easily operable, by a single hand motion, from the inside at all times without keys. Deadbolts or turn buttons on the inside of exit doors shall be disabled.
(e) Exit doors shall be free of all obstructions or impediments to allow for full instant use in case of fire or other emergency.
(f) Steps, porches, stoops, and ramps shall be provided with handrails or guardrails.
(g) In each overnight respite services program with at least one participant who is determined by a physician or appropriate licensed health professional or is otherwise known to be disoriented or who wanders, each exit door for participant-use shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office area or in a location accessible only to staff authorized by the administrator to operate the control panel.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0313 LAUNDRY ROOM
If the facility uses laundry equipment, the equipment shall not be located in the living, dining, or bedroom areas.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0314 FLOORS
(a) All floors shall be of smooth, non-skid material and shall be cleanable.
(b) Scatter or throw rugs shall not be used.
(c) All floors shall be kept free of damage.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0315 HOUSEKEEPING AND FURNISHINGS
(a) Each overnight respite services program shall:
(1) have walls, ceilings, and floors or floor coverings kept clean, well maintained, and free of damage;
(2) have no lingering odors;
(3) have furniture clean and free of damage;
(4) have a North Carolina Environmental Health Services Section approved sanitation classification at all times;
(5) be maintained in an uncluttered, clean, and orderly condition, free of all obstructions and hazards;

(6) have a supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for participant use on hand at all times;
(7) make available the following items as needed but shall not charge the participant's personal funds for the cost of these items:
(A) protective sheets and clean, absorbent, soft, and smooth pads;
(B) bedpans, urinals, hot water bottles, and ice bags; and
(C) bedside commodes, walkers, and wheelchairs;
(8) have a television and radio, each in good working order;
(9) have curtains, draperies, shades, or blinds at all windows in participant-use areas to provide for participant privacy;
(10) have recreational equipment, supplies for games, books, magazines, and a current newspaper available for participants;
(11) have a clock that has numbers at least 1½ inches tall in an area commonly used by the participants; and
(12) have at least one working telephone that does not depend on electricity or cellular service to operate.
(b) Each bedroom shall have the following furnishings for each participant:
(1) beds equipped with box springs and mattress, solid link springs and no-sag innerspring, or a foam mattress. A hospital bed shall be provided as needed. A water bed may be allowed if requested by a participant and permitted by the overnight respite services program. Each bed shall have the following:
(A) at least one pillow with clean pillow case;
(B) clean top and bottom sheets on the bed, changed at least once a week; and
(C) clean bedspread and other clean coverings as needed;
(2) a bedside-type table;
(3) a chest of drawers or bureau for a single participant or a double chest of drawers or double dresser for two participants when not provided as built-ins;
(4) a wall or dresser mirror;
(5) a minimum of one comfortable chair per participant, high enough from the floor for easy rising;
(6) additional chairs available, as needed, for use by visitors;
(7) a clean towel, wash cloth, and towel bar within the bedroom or adjoining bathroom; and
(8) a wall-mounted light overhead of the bed or a lamp with a switch within reach of a person lying on the bed. The light shall provide a minimum of 30 foot-candle power of illumination for reading.
(c) The living room shall have living room furnishings for the comfort of participants with coverings that are cleanable.
(d) The dining room shall have the following furnishings:
(1) tables and chairs to seat all participants eating in the dining room; and
(2) chairs that are sturdy, non-folding, without rollers unless retractable or on front legs only, and designed to minimize tilting.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0316 FIRE SAFETY AND DISASTER PLAN
(a) Fire extinguishers shall be provided that meet these requirements:
(1) one five-pound or larger (net charge) "A-B-C" type centrally located;
(2) one five-pound or larger "A-B-C" or CO/2 type located in the kitchen; and
(3) at any other location as required by the North Carolina Fire Prevention Code, which is incorporated herein by reference including subsequent amendments and editions. The availability and cost of the Code is set forth in Rule .0302 of this Section.
(b) All fire safety requirements required by city or county ordinances shall be met.
(c) A written fire evacuation plan that includes a diagram and that has the approval of the local fire marshal shall be prepared and posted in a central location on each floor. The plan shall be reviewed with each participant on enrollment and shall be a part of the orientation for new staff.

(d) There shall be at least four rehearsals of the fire evacuation plan each year on each shift. Records of rehearsals shall be maintained for three years. The records shall include the date and time of the rehearsals, staff members present, and a description of what the rehearsal involved.
(e) A written disaster plan that has the written approval of, or has been documented as submitted to, the local emergency management agency and the local agency designated to coordinate special needs sheltering during disasters shall be prepared and updated annually and shall be maintained in the program offering overnight respite care services.

History Note: *Authority G.S. 131D-6.1;*
Eff. April 1, 2017.

10A NCAC 13E .0317 BUILDING SERVICE EQUIPMENT
(a) The building and all fire safety, electrical, mechanical, and plumbing equipment shall be maintained in a safe and operating condition.
(b) There shall be a central heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. Built-in electric heaters, if used, shall be installed or protected so as to avoid hazards to participants and room furnishings. Unvented fuel burning room heaters and portable electric heaters shall be prohibited.
(c) Air conditioning shall provide conditions not to exceed 81 degrees F (27 degrees C) under summer design conditions.
(d) The hot water tank shall be of such size to provide as much hot water as is needed by the kitchen, bathrooms, and laundry. The hot water temperature at all fixtures used by participants shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C).
(e) All participant-use areas shall be lighted for the safety and comfort of the participants. The minimum lighting required is:

(1) 30 foot-candle of light at floor level in living rooms, dining rooms, bedrooms, and bathrooms;
(2) 10 foot-candle of light for general lighting; and
(3) one foot-candle of light at the floor for corridors at night.

(f) Fireplaces, fireplace inserts, and wood stoves shall be designed or installed so as to avoid a burn hazard to participants. Fireplace inserts and wood stoves must be Underwriters Laboratories (U.L.) listed.
(g) Gas logs may be installed if they are of the vented type, installed according to the manufacturers' installation instructions, approved by the local building code official, and protected by a guard or screen to prevent participants and furnishings from burns.

History Note: *Authority G.S. 131D-6.1;*
Eff. April 1, 2017.

10A NCAC 13E .0318 OUTSIDE PREMISES
(a) The outside grounds of the program shall be maintained in a clean and safe condition.
(b) If the facility has a fence around the premises, the fence shall not prevent participants from exiting or entering freely and shall not be hazardous.
(c) Outdoor stairways and ramps shall be illuminated by no less than five foot candles of light at grade level.

History Note: *Authority G.S. 131D-6.1;*
Eff. April 1, 2017.

SECTION .0400 – STAFF QUALIFICATIONS AND STAFFING

10A NCAC 13E .0401 ADMINISTRATOR
(a) An administrator shall be responsible for the operations of the program offering overnight respite care services.
(b) At all times there shall be one administrator or supervisor-in-charge who is responsible for assuring that all required duties are carried out and for assuring that a staff member is present on-site and available to the program participants.
(c) The administrator shall:

(1) be at least 21 years old;
(2) be a high school graduate or certified under the General Educational Development (GED) Program;

(3) cooperate with inspectors and DHSR employees in assuring compliance with G.S. 131D-6.1 and the rules of this Subchapter;
(4) have a tuberculin skin test within 12 months prior to hire date and annually thereafter;
(5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry pursuant to G.S. 131E-256;
(6) have documented evidence of managing or supervising personal care to others for at least six months from a current or previous employer; and
(7) be able to implement all accident, fire safety, and emergency procedures for the protection of the participants of the overnight respite services program.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0402 SUPERVISOR-IN-CHARGE
(a) The supervisor-in-charge is responsible to the administrator for the operation of the overnight respite services program in the absence of the administrator.
(b) The supervisor-in-charge shall meet the same requirements as the administrator as set forth in Rule .0401(c) of this Section.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0403 STAFF AND STAFFING
(a) Each staff person shall:
(1) have a job description that reflects actual duties and responsibilities determined by the program and shall be signed by the administrator and the employee;
(2) have a tuberculin skin test within 12 months prior to hire and annually thereafter;
(3) be able to implement all of the program's policies and procedures as defined in Rule .0501 of this Subchapter and accident, fire safety, and emergency procedures for the protection of the participants;
(4) be informed of the confidential nature of participant information and protect and preserve the information from unauthorized use and disclosure;
(5) not hinder or interfere with the exercise of the rights as defined by program policy;
(6) have no substantiated findings listed on the North Carolina Health Care Personnel Registry pursuant to G.S. 131E-256;
(7) have a statewide criminal background check, upon hire, of the past five years in accordance with G.S. 143B-932; and
(8) cooperate with inspectors and the monitoring and licensing agencies in complying with the rules of this Subchapter.
(b) Any staff member left in charge of the care of participants shall be 18 years or older.
(c) The staffing pattern shall be adequate to meet the needs of each participant, with at least one staff present at all times qualified to administer medications as defined by Rule .0702 of this Subchapter and trained to provide personal care and supervision to current participants.
(d) Services required beyond personal care and supervision shall not be provided unless staff satisfies the license requirements applicable to such services.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0404 TRAINING ON CARDIO-PULMONARY RESUSCITATION
At least one staff person shall be on the premises at all times, when participants are present, who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute, Medic First Aid, or a trainer with documented certification as a trainer on these procedures from one of these organizations.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

SECTION .0500 – PROGRAM POLICIES

10A NCAC 13E .0501 PROGRAM POLICIES

(a) Each program shall have enrollment policies. Enrollment policies shall be in writing as a part of the program policies and shall define the population served. These policies shall serve as the basis for determining who will be accepted into the program and for planning activities appropriate for the participants. The policies shall prevent enrolling people whose needs cannot be met by the planned activities and services offered and shall provide for discharge of participants whose needs can no longer be met or who can no longer be cared for safely. If the program serves semi-ambulatory or non-ambulatory persons as defined by 10A NCAC 06R .0201, it shall be stated in the enrollment criteria.

(b) The program policies shall also contain:

- (1) a discharge policy outlining:
  - (A) the criteria for discharge;
  - (B) notification procedures for discharge;
  - (C) the timeframe and procedures for notifying the applicant, family member, or other caregiver of discharge; and
  - (D) referral or follow-up procedures;
- (2) medication policies and procedures as specified in Section .0700 of this Subchapter;
- (3) a description of participant's rights;
- (4) grievance policies and procedures for families;
- (5) the advance directives policy;
- (6) non-discrimination policies;
- (7) a procedure to maintain confidentiality;
- (8) a policy on reporting suspected abuse or neglect;
- (9) a policy on reporting of participant accidents or incidents to family members or medical providers;
- (10) a policy on infection control and universal precautions;
- (11) a policy on missing participants;
- (12) a policy on identification and supervision of participants who wander; and
- (13) inclement weather policies.

(c) At enrollment or in the initial interview, the program policies shall be discussed with the applicant, responsible party or other caregiver and a copy of the program policies shall be provided.

(d) Documentation of, receipt of, and agreement to abide by the program policies by the applicant, responsible party, or other caregiver shall be obtained by the program and kept in the participant's file.

(e) All program polices shall be maintained on site and available for inspection by Division of Health Service Regulation employees.

(f) The program shall implement all program policies.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

SECTION .0600 - ENROLLMENT AND SERVICE PLANNING

10A NCAC 13E .0601 ENROLLMENT OF PARTICIPANTS

(a) Prior to enrollment the applicant, responsible party, or other caregiver shall have a personal interview with a program staff member. During the interview, the staff shall complete initial documentation identifying the following:

- (1) social and medical care needs;
- (2) spiritual, religious, or cultural needs; and
- (3) whether the program can meet the applicant's expressed needs.

The staff person doing the interviewing shall sign the assessment of needs and the applicant, responsible party, or other caregiver shall sign the application for enrollment. These signed documents shall be obtained before the individual's first day of attendance as a participant in the program and shall be maintained in the participant's record.

(b) Any adult (18 years of age or over) who, because of a physical condition or mental disability, needs a substitute home for purpose of respite for the caregiver may be enrolled for overnight respite services when, in the opinion of the caregiver, family, participant, physician, appropriate licensed health professional, or social worker and the administrator, the services and accommodations of the facility will meet the respite needs of the participant.
(c) Individuals shall not be admitted:

(1) for treatment of mental illness or alcohol or drug abuse;
(2) for maternity care;
(3) for professional nursing care under continuous medical supervision;
(4) for lodging, when the personal assistance and supervision offered for the participant are not needed; or
(5) who pose a threat to the health or safety of others.

(d) A medical examination report signed by a physician or appropriate licensed health professional completed within the prior three months, shall be obtained by the program at the time of enrollment. The report must be updated annually no later than the anniversary date of the initial report.
(e) The program shall assure that the participant's physician or appropriate licensed health professional is contacted for orders for medications, treatments, and special diets if current physician orders are not part of the medical examination report required in Paragraph (d) of this Rule for inclusion in the participant's record. Prior to or the day of admission, the participant's physician or appropriate licensed health professional shall be contacted for clarification of orders, if orders are not clear or complete.
(f) The program shall assure that the participant has been tested for tuberculosis disease within the past 12 months of each admission for overnight respite services in accordance with the NC Division of Public Health's Tuberculosis Policy Manual, incorporated herein by reference including any subsequent amendments and editions, and shall be free of active tuberculosis. This manual may be accessed free of charge at http://epi.publichealth.nc.gov/cd/lhds/manuals/tb/toc.html.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0602 PLANNING SERVICES FOR INDIVIDUAL PARTICIPANTS

(a) At enrollment of a new participant, the program shall perform an assessment and written service plan for the individual. The assessment shall address the individual's ability to perform activities of daily living and need for supervision while in the program. The mental and physical health status of the individual shall also be assessed. The service plan shall be signed and dated by the administrator or designee. The health component of the service plan shall be written and signed by a registered nurse.
(b) In developing the written service plan, the program shall include input from the participant, responsible party, other caregiver and other agency professionals with knowledge of the individual's needs. The service plan shall be based on strengths, needs, and abilities identified in the assessment. The assessment and service plan shall be reviewed to assure continued accuracy at each admission for overnight respite services. The service plan shall include:

(1) the needs and strengths of the participant;
(2) the interests of the participant;
(3) the service goals and objectives of care for the participant while in the overnight respite program;
(4) the type of interventions to be provided by the program in order to reach desired outcomes;
(5) the services to be provided by the program to achieve the goals and objectives;
(6) the roles of the participant, responsible party, other caregiver, volunteers and program staff; and
(7) the time limit for the plan, with provision for review and renewal.

(c) The participant, responsible party, other caregiver and other service providers may contribute to the development, implementation, and evaluation of the service plan.
(d) The participant's record shall include:

(1) a copy of the medical examination report;
(2) the written service plan;
(3) documentation of a tuberculosis test according to Rule .0601(f) of this Section;
(4) documentation of any contacts (office, home or telephone) with the participant's physician or other licensed health professionals from outside the facility;
(5) physician orders;
(6) medication administration records;

(7) a written description of any acute changes including any unusual behavior, change in condition, need for help or services, or any incidents or accidents resulting in injury to the participant, and any action taken by the facility in response to the changes, incidents or accidents; and

(8) how the responsible party or his or her designated representative can be contacted in case of an emergency.

(e) The program shall refer a participant to the participant's physician or other appropriate licensed health professional immediately if the participant's behavior, change in condition, any incidents or accidents resulting in injury to the participant, or need for help or services poses an immediate risk to the health and safety of the participant, other participants, or staff in the program.

(f) Any unusual behavior, change in condition, incident or accident resulting in injury to the participant, or need for help or services shall be reported by the program staff to the responsible party.

(g) Progress notes in the participant's record shall be updated every 24 hours while in the program.

(h) The participant or the responsible party may choose the days and number of days the participant will participate in the program with the administrator's approval and documented in the participant's record.

(i) The reason for any unscheduled participant absence shall be documented by the program staff on the day it occurs. Program staff shall contact or attempt to contact the absent participant or the responsible party and shall document this contact in the participant's record.

(j) The program is responsible for the participant while the participant is enrolled. A participant leaving the program for part of a day shall sign out, relieving the staff of further responsibility. If a participant has an emotional or mental impairment that requires supervision or is adjudicated incompetent, and that person needs or wants to leave the program during the day, the responsible party or individuals designated by the responsible party shall sign the participant out.

(k) The participant's responsible party or his or her designated representative shall be contacted and informed of the need to remove the participant from the program if one or more of the following conditions exists:

(1) the participant's condition is such that he or she is a danger to himself or herself, or poses a direct threat to the health of others, as documented by a physician or appropriate licensed health professional; or

(2) the safety of individuals in the facility is threatened by the behavior of the participant, as documented by the facility.

Documentation of the emergency discharge shall be retained on file in the facility.

(l) After the participant has left the program or died, the program shall maintain the participant's record in the facility for one year, and then stored for two more years.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

SECTION .0700 - MEDICATION ADMINISTRATION

10A NCAC 13E .0701 MEDICATION ADMINISTRATION POLICIES AND PROCEDURES

There shall be written policies and procedures developed and implemented regarding:

(1) medication administration;

(2) documentation of medication administration;

(3) maintenance of documentation;

(4) documentation and reporting of medication errors; and

(5) medication storage and disposition.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0702 MEDICATION ADMINISTRATION COMPETENCY EVALUATION

(a) Validation of each staff person's competency to administer medications shall be completed prior to administering medications and shall include:

(1) documentation by a registered nurse pursuant to G.S. 90 Article 9A or a licensed pharmacist pursuant to G.S. 90 Article 4A of a clinical skills validation on the Medication Administration Skills Validation Form. Copies of this form may be accessed electronically free of charge at https://info.ncdhhs.gov/dhsr/acls/acforms.html#medtest;

(2) successful completion of a standardized written exam established by the Division of Health Service Regulation; or

(3) being listed as a medication aide on the NC Medication Aide Registry pursuant to G.S. 131E-270 and 10A NCAC 13O .0201.

(b) The program shall ensure that a licensed health professional who is authorized to dispense, prescribe, or administer medications is available for consultation with staff. All such consultations shall be documented in the participant's record.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017;
Amended September 1, 2019.

10A NCAC 13E .0703 MEDICATION ADMINISTRATION

(a) Medications shall be administered according to current physician's or appropriate licensed health professional's orders and the participant's medication schedule. The medication schedule shall list all medications with dosages and times that medications are to be administered.

(b) A record of all medication given to each participant shall be accurate and include the following:

(1) the participant's name;

(2) the name, dosage, quantity, and route of the medication;

(3) instructions for giving medication;

(4) the date and time medication is administered; and

(5) the name or initials of person giving the medication. If initials are used, a signature for those initials shall be documented and maintained in this record.

(c) Medications shall be kept in the original pharmacy containers in which they were dispensed. The containers shall be labeled with the participant's full name, the name and strength of the medicine, and dosage and instructions for administration. Medicines shall be kept in a locked location.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

SECTION .0800 - NUTRITION AND FOOD SERVICE

10A NCAC 13E .0801 FOOD PROCUREMENT AND SAFETY

(a) The kitchen, dining, and food storage areas shall be clean and maintained in a sanitary condition in accordance with Rules Governing the Sanitation of Residential Care Facilities (15A NCAC 18A .1600) as promulgated by the North Carolina Division of Public Health, Environmental Health Services Section, which are incorporated herein by reference including subsequent amendments and editions.

(b) All food and beverages shall be procured, stored, prepared, or served by the facility under sanitary conditions in accordance with Rules Governing the Sanitation of Residential Care Facilities (15A NCAC 18A .1600).

(c) All meat served to participants shall have been processed at a plant approved by the United States Department of Agriculture (USDA).

(d) There shall be at least a three-day supply of perishable food and a five-day supply of non-perishable food on site, as indicated on the menus prepared as set forth in Rule .0802 of this Section, for both regular and therapeutic diets.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0802 FOOD PREPARATION AND SERVICE

(a) Staff, space, and equipment shall be provided for safe and sanitary food storage, preparation, and service.

(b) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the participant.

(c) If participants require assistance with eating, food shall be maintained at serving temperature until assistance is provided.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0803 MENUS

(a) Menus shall be prepared according to the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Agriculture (USDA) Dietary Guidelines for Americans, which is incorporated by reference with all subsequent amendments and editions and is available at no cost at http://www.health.gov/dietaryguidelines.
(b) Menus shall be maintained in the kitchen and identified as to the current menu day, and cycle for any given day for guidance of food service staff.
(c) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets, and documented to indicate the foods actually served to participants.
(d) Menus shall be planned to take into account the food preferences and customs of the participants.
(e) A licensed dietitian or nutritionist, pursuant to G.S. 90, Article 25, shall plan or review all menus, including all therapeutic diets. The facility shall maintain verification of the licensed dietitian or nutritionist's approval of the therapeutic diets, including an original signature by the licensed dietitian or nutritionist and the licensure number of the licensed dietitian or nutritionist.
(f) The facility shall have a matching therapeutic diet menu for all physician or appropriate licensed health professional ordered therapeutic diets, for guidance of food service staff.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0804 FOOD REQUIREMENTS

(a) A minimum of three meals a day shall be served.
(b) Foods and beverages that are appropriate to overnight respite participants' diets shall be offered or made available to overnight respite participants as snacks between each meal for a total of three snacks per day and shall be shown on the menu as snacks.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0805 THERAPEUTIC DIETS

(a) All therapeutic diet orders, including thickened liquids, shall be in writing from the participant's physician or appropriate licensed health professional.
(b) Where applicable, the therapeutic diet order shall be specific to calorie, gram, or consistency, such as for calorie-controlled American Diabetic Association diets, low sodium diets, or thickened liquids, unless there are written orders that include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a licensed dietitian or nutritionist.
(c) The facility shall maintain an accurate and current listing of overnight respite participants with physician or appropriate licensed health professional ordered therapeutic diets for guidance of food service staff.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0806 ASSISTANCE WITH EATING

(a) Staff shall provide assistance with eating as needed.
(b) Food shall be maintained at serving temperature until assistance with eating is provided.
(c) Participants needing assistance with eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each participant's dignity.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

10A NCAC 13E .0807 ACCOMMODATION OF PARTICIPANT NEEDS AND PREFERENCES

Variations from the required three meals to meet individualized needs or preferences of participants shall be documented in the participant's record.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

SECTION .0900 - PROGRAM ACTIVITIES

10A NCAC 13E .0901 ACTIVITIES PROGRAM

(a) There shall be a program of activities designed to promote the participants' active involvement with each other, their families, and the community.
(b) If there is a question about a participant's ability to participate in an activity, the participant, the participant's physician or appropriate licensed health professional, family, or responsible party shall be consulted to obtain a statement regarding the participant's capabilities.

History Note: Authority G.S. 131D-6.1;
Eff. April 1, 2017.

SUBCHAPTER 13F – LICENSING OF ADULT CARE HOMES OF SEVEN OR MORE BEDS

SECTION .0100 - DEFINITIONS

10A NCAC 13F .0101 DEFINITIONS

History Note: Authority G.S. 131D-2; 143B-153;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Repealed Eff. July 1, 2005.

10A NCAC 13F .0102 LIST OF DEFINITIONS

As used in this Subchapter, the following definitions shall apply:

(1) "Abuse" means the term as defined in G.S. 131D-2.1.
(2) "Activities of daily living" or "ADL's" means eating, dressing, bathing, toileting, bowel and bladder control, transfers, ambulation, and communication.
(3) "Acute care needs" means symptoms or a condition that develops quickly and is not a part of the resident's baseline health or mental health status or is a change or worsening in the symptoms of a resident's chronic condition, which may have a slower onset and worsen over time.
(4) "Administrator" means the term as defined in G.S. 90-288.13 and G.S. 131D-2.1.
(5) "Adult care home" means the term as defined in G.S. 131D-2.1.
(6) "Alternative examination" means a test developed and administered by the Department to meet the educational requirements of an activity director, administrator-in-charge, manager, or personal care aide supervisor for those applicants who do not possess a high school diploma or General Education Diploma (G.E.D.) prior to September 1, 2024.
(7) "Aide duty" means time spent by qualified staff providing assistance with activities of daily living, medication administration, or supervision of residents as determined by the resident's assessment, care plan, physician's orders, and current symptoms.
(8) "Department" means the North Carolina Department of Health and Human Services.
(9) "Discharge" means a resident's termination of their residency at the adult care home, resulting in the resident's move to another location.
(10) "Exploitation" means the term as defined in G.S. 131D-2.1.
(11) "Facility" means a licensed adult care home.
(12) "First shift" means the hours of work between 7:01 a.m. and 3:00 p.m.
(13) "Food service duties" means tasks performed by staff related to serving meals to residents, including assisting with food preparation, arranging and setting the dining tables, serving food and beverages, and cleaning the dining room after meal service is complete.

(14) "Housekeeping duties" means tasks performed by staff such as cleaning and sanitizing facility common areas and resident rooms.
(15) "Legal representative" means a person authorized by state or federal law (including, but not limited to, power of attorney, legal guardian, or representative payee) to act on behalf of the resident to support the resident in decision-making; access medical, social, or other personal information of the resident; and manage financial matters or receive notifications.
(16) "Long-term care" means a continuum of care and services available in an individual's community that provides the care and support required during a persistent or chronic health condition, such as when a person is unable to independently perform some or all activities of daily living or requires supervision due to physical or cognitive impairment.
(17) "Manager" means an individual responsible for the day-to-day operation of an adult care home in the absence of the administrator and under the direction and supervision of the administrator as described in Rule .0402 of this Subchapter.
(18) "Medication aide" means an individual who administers medications to residents and meets all requirements as set forth in Rule .0403 of this Subchapter.
(19) "Neglect" means the term as defined in G.S. 131D-2.1.
(20) "On-call" means able to be contacted by two-way telecommunication.
(21) "On-duty" in reference to an administrator means the administrator is on-site and directly responsible for the day-to-day operations of a facility. "On-duty" in reference to a manager means a manager designated by the administrator as required in Rule .0402 of this Subchapter and who is on-site and directly responsible for the day-to-day operations of a facility under the direction and supervision of the administrator.
(22) "Personal care aide" means a staff member who performs personal care services as defined by G.S. 131D-2.1.
(23) "Physical restraint" means any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily, and which restricts freedom of movement or normal access to one's body.
(24) "Physician extender" means a licensed physician assistant or a licensed nurse practitioner.
(25) "Resident" means the term as defined in G.S. 131D-2.1.
(26) "Responsible person" means a person chosen by the resident to act on their behalf to support the resident in decision-making; have access to medical, social, or other personal information of the resident; manage financial matters; or receive notifications.
(27) "Second shift" means the hours of work between 3:01 p.m. and 11:00 p.m.
(28) "Staff" means any person who performs duties as an employee, paid or unpaid, on behalf of the adult care home.
(29) "Supervision" means oversight, monitoring, and interventions implemented by the facility for the purpose of mitigating the risk of an accident, incident, illness, or injury to a resident to ensure the health, safety, and welfare of the resident and other residents.
(30) "Supervisor" means a personal care aide supervisor as defined in Rule .0609 of this Subchapter.
(31) "Third shift" means the hours of work between 11:01 p.m. and 7:00 a.m.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. September 1, 2024.

SECTION .0200 – LICENSING

10A NCAC 13F .0201 DEFINITIONS

The following definitions shall apply throughout this Section:

(1) "Person" means an individual; a trust or estate; a partnership; a corporation; or any grouping of individuals, each of whom owns five percent or more of a partnership or corporation, who collectively own a majority interest of either a partnership or a corporation.
(2) "Owner" means any person who has or had legal or equitable title to or a majority interest in an adult care home.
(3) "Affiliate" means any person that directly or indirectly controls or did control an adult care home or any person who is controlled by a person who controls or did control an adult care home. In addition, two or more adult care homes who are under common control are affiliates.

(4) "Principal" means any person who is or was the owner or operator of an adult care home, an executive officer of a corporation that does or did own or operate an adult care home, a general partner of a partnership that does or did own or operate an adult care home, or a sole proprietorship that does or did own or operate an adult care home.

(5) "Indirect control" means any situation where one person is in a position to act through another person over whom the first person has control due to the legal or economic relationship between the two.

History Note: Authority G.S. 131D-2.4; 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .0202 THE LICENSE

(a) Except as otherwise provided in G.S. 131D-2.4, the Department shall issue an adult care home license to any person who submits the application material according to Rule .0204 of this Section and the Department determines that the applicant complies with the provisions of all State adult care home licensure statutes and rules of this Subchapter. All applications for a new license shall disclose the names of individuals who are co-owners, partners, or shareholders holding an ownership or controlling interest of five percent or more of the applicant entity.
(b) The license shall be posted in a publicly viewable place in the home.
(c) When a provisional license is issued according to G.S. 131D-2.7, the administrator shall post the provisional license and a copy of the notice from the Division of Health Service Regulation identifying the reasons for it, in a publicly viewable place in the home and in place of the full license.
(d) The license is not transferable or assignable.
(e) An adult care home shall be licensed only as an adult care home and not for any other level of care or licensable entity or service. The license shall be terminated when the home is licensed to provide a higher level of care or a combination of a higher level of care and adult care home level of care.

History Note: Authority G.S. 131D-2.4; 131D-2.7; 131D-2.16; 131D-4.5; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;
Amended Eff. June 1, 2020.

10A NCAC 13F .0203 PERSONS NOT ELIGIBLE FOR NEW ADULT CARE HOME LICENSES

History Note: Authority G.S. 131D-2.4; 131D-2.5; 131D-4.5; 131D-2.16; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Repealed Eff. January 1, 2020.

10A NCAC 13F .0204 APPLYING FOR A LICENSE TO OPERATE A FACILITY NOT CURRENTLY LICENSED

(a) Prior to submission of a license application, all Certificate of Need requirements shall be met according to G.S. 131E, Article 9.
(b) In applying for a license to operate an adult care home to be constructed or renovated, or in an existing building that is not currently licensed, the applicant shall submit the following to the Division of Health Service Regulation:

(1) the Initial License Application that is available online at https://info.ncdhhs.gov/dhsr/acls/pdf/fcchgapp.pdf at no cost and includes the following:
   (A) contact person, facility site and mailing addresses, and administrator;
   (B) operation disclosure including names and contact information of the licensee, management company, and building owner;
   (C) ownership disclosure including names and contact information of owners, principals, affiliates, shareholders, and members; and
   (D) bed capacity including that of any special care unit for Alzheimer's and Related Disorders;
(2) plans and specifications as required in Section .0300 of this Subchapter and a construction review fee according to G.S. 131E-267 to be calculated and invoiced by the DHSR Construction Section;
(3) an approved fire and building safety inspection report from the local fire marshal to be submitted upon completion of construction or renovation;
(4) an approved sanitation report or a copy of the permit to begin operation from the sanitation division of the county health department to be submitted upon completion of construction or renovation;
(5) a nonrefundable license fee as required by G.S. 131E-272; and
(6) a certificate of occupancy or certification of compliance from the local building official to be submitted upon completion of construction or renovation.

(c) Issuance of an adult care home license shall be based on the following:
(1) completion of and approval in accordance with Subparagraphs (b)(1) through (b)(6) of this Rule;
(2) the Division of Health Service Regulation's Construction Section's recommendation of licensure based on compliance with rules in Section .0300 of this Subchapter;
(3) a compliance history review of the facility and its principals and affiliates according to G.S. 131D-2.4;
(4) approval by the Adult Care Licensure Section of the facility's operational policies and procedures based on compliance with the rules of this Subchapter; and
(5) the facility's demonstration of compliance with Adult Care Home statutes and rules of this Subchapter as determined by a pre-licensing survey of the facility by the Adult Care Licensure Section.

(d) The Adult Care Licensure Section shall notify in writing the applicant licensee and the county department of social services of the decision to license or not to license the adult care home based on compliance with adult care home statutes and the rules of this Subchapter within 14 days from the decision to license or not to license the facility.

History Note: Authority G.S. 131D-2.4; 131D-2.5; 131D-2.16; 143B-165;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;
Amended Eff. June 1, 2020.

10A NCAC 13F .0205 APPLICATION TO LICENSE A NEWLY CONSTRUCTED OR RENOVATED BUILDING

History Note: Authority G.S. 131D-2; 143B-153; 143B-165; S.L. 2002-160; 2003-0284;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Temporary Amendment Eff. September 1, 2003;
Repealed Eff. June 1, 2004.

10A NCAC 13F .0206 CAPACITY

(a) The licensed capacity of adult care homes licensed pursuant to this Subchapter is seven or more residents.

(b) The total number of residents shall not exceed the number shown on the license.
(c) The Department shall not grant a license to a facility for more beds than permitted by the rules of this Subchapter.
(d) The facility's bed capacity and services provided shall comply with the Certificate of Need issued to the facility in accordance with G.S. 131E, Article 9.

History Note: *Authority G.S. 131D-2.4; 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;
Amended Eff. April 1, 2025.

10A NCAC 13F .0207 CHANGE OF LICENSEE

Prior to the sale of an adult care home business, the current and prospective licensee shall meet the requirements of this Rule.

(1) The current licensee shall provide written notification of a planned change of licensee to the Division of Health Service Regulation, the county department of social services, and the residents or their responsible persons at least 30 days prior to the date of the planned change of licensee.
(2) If the prospective licensee plans to purchase the building, the prospective licensee shall provide the Healthcare Planning and Certificate of Need Section of the Division of Health Service Regulation with prior written notice as required by G.S. 131E-184(a)(8) prior to the purchase of the building.
(3) The prospective licensee shall submit the following license application material to the Division of Health Service Regulation:
    (a) the Change Licensure Application for Adult Care Home (7 or more Beds) that is available on the internet website, https://info.ncdhhs.gov/dhsr/acls/pdf/acchgapp.pdf at no cost and includes the following:
        (i) facility administrator and building owner information;
        (ii) operation disclosure including new licensee information and management company, if any; and
        (iii) ownership disclosure including new owners, principles, affiliates, shareholders, and members;
    (b) a fire and building safety inspection report from the local fire marshal dated within the past 12 months;
    (c) a sanitation report from the sanitation division of the county health department dated within the past 12 months; and
    (d) a nonrefundable license fee as required by G.S. 131D-2.5.

History Note: *Authority G.S. 131D-2.4; 131D-2.5; 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Temporary Amendment Eff. September 1, 2003; July 1, 2003;
Amended Eff. June 1, 2004;
Readopted Eff. January 1, 2020.

10A NCAC 13F .0208 RENEWAL OF LICENSE

(a) The licensee shall file a license renewal application annually on a calendar year basis on the forms provided by the Department at no cost with a nonrefundable annual license fee according to G.S. 131D-2.5. The renewal application form includes the following:

(1) contact person, facility site and mailing address, and administrator;

(2) operation disclosure including names and contact information of the licensee, management company, and building owner;
(3) ownership disclosure including names and contact information of owners, principals, affiliates, shareholders, and members holding an ownership or controlling interest of five percent or more of the applicant entity;
(4) bed capacity including that of any special care unit for Alzheimer's and Related Disorders; and
(5) population and census data.

(b) In determining whether to renew a license under G.S. 131D-2.4, the Department shall take into consideration at least the following:
(1) the compliance history of the applicant facility with the provisions of all State adult care home licensure statutes and rules of this Subchapter;
(2) the compliance history of the owners, principals, and affiliates of the applicant facility in operating other adult care homes in the State;
(3) the extent to which the conduct of the licensee, including owners, principals, affiliates, and persons and those with indirect control as defined in Rule .0201 of this Section, is likely to affect the quality of care at the applicant facility; and
(4) the hardship on residents of the applicant facility if the license is not renewed.

(c) When violations of licensure rules or statutes are documented by the Department and have not been corrected by the facility prior to license expiration, the Department shall either approve a continuation or extension of a plan of correction, issue a provisional license, or deny the license.

History Note: *Authority G.S. 131D-2.4; 131D-2.5; 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;
Amended Eff. June 1, 2020.

10A NCAC 13F .0209 CONDITIONS FOR LICENSE RENEWAL

History Note: *Authority G.S. 131D-2.4; 131D-2.16; 143B-165;*
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;
Repealed Eff. June 1, 2020.

10A NCAC 13F .0210 TERMINATION OF LICENSE

History Note: *Authority G.S. 131D-2; 143B-153; 143B-165; S.L. 2002-160; 2003-0284;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Temporary Amendment Eff. September 1, 2003;
Repealed Eff. June 1, 2004.

10A NCAC 13F .0211 NOTIFICATION ABOUT CLOSING OF HOME

If a licensee plans to close a home, the licensee shall provide written notification of the planned closing to the Division of Health Service Regulation, the county department of social services and the residents or their

responsible persons at least 30 days prior to the planned closing. Written notification shall include date of closing and plans made for the move of the residents.

History Note: Authority G.S. 131D-2.4; 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .0212 DENIAL OR REVOCATION OF LICENSE

(a) A license may be denied by the Division of Health Service Regulation for failure to comply with the rules of this Subchapter.
(b) Denial of a license by the Division of Health Service Regulation shall be effected by mailing to the applicant licensee, by registered mail, a notice setting forth the particular reasons for such action.
(c) A license may be revoked by the Division of Health Service Regulation in accordance with G.S. 131D-2.7(b) and G.S. 131D-29.
(d) When a facility receives a notice of revocation, the administrator shall inform each resident and the resident's responsible person in writing of the notice and the basis on which it was issued within five calendar days of the notice of revocation being received by the licensee of the facility.

History Note: Authority G.S. 131D-2.7; 131D-2.16; 131D-4.3; 131D-29; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;
Amended Eff. June 1, 2020.

10A NCAC 13F .0213 APPEAL OF LICENSURE ACTION

The licensee of an adult care home may appeal a licensure action by commencing a contested case according to G.S. 150B-23 following attempts at informal resolution according to G.S. 150B-22.

History Note: Authority G.S. 131D-2.4; 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. July 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .0214 SUSPENSION OF ADMISSIONS

History Note: Authority G.S. 131D-2.7;
Eff. January 1, 1982;
Repealed Eff. January 1, 2020.

10A NCAC 13F .0215 ADMINISTRATIVE PENALTY DETERMINATION PROCESS

History Note: Authority G.S. 131D-34; 143B-165;
Eff. December 1, 1993;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Repealed Eff. October 1, 2016.

SECTION .0300 - PHYSICAL PLANT

10A NCAC 13F .0301 APPLICATION OF PHYSICAL PLANT REQUIREMENTS

Adult Care Homes shall apply the following physical plant requirements:

(1) New construction shall comply with the requirements of this Section.

(2) Except where otherwise specified, existing licensed facilities or portions of existing licensed facilities shall meet the licensure and code requirements in effect at the time of licensure, construction, change in service or bed count, addition, modification, renovation, or alteration.

(3) New additions, alterations, modifications, and repairs shall meet the requirements of this Section.

(4) Effective July 1, 1987, resident bedrooms and resident services shall not be permitted on the second floor of a facility licensed for seven or more beds prior to April 1, 1984 and classified as two-story wood frame construction by the North Carolina State Building Code.

(5) Rules contained in this Section are minimum requirements and are not intended to prohibit buildings, systems, or operational conditions that exceed minimum requirements.

(6) The Division may grant an equivalency to allow alternate methods, procedures, design criteria, or functional variation from the requirements of this Rule and the rules contained in this Section. The equivalency may be granted by the Division when a facility submits a written equivalency request to the Division that states the following:

(a) the rule citation and the rule requirement that will not be met because strict conformance with current requirements would be:

(i) impractical;

(ii) unable to be met due to extraordinary circumstances. For the purpose of this Rule, "extraordinary circumstances" means situations that are unexpected and beyond the control of the facility; or

(iii) unable to be met due to new programs.

(b) the justification for the equivalency; and

(c) how the proposed equivalency meets the intent of the corresponding rule requirement.

(7) In determining whether to grant an equivalency request, the Division shall consider whether the request will reduce the safety and operational effectiveness of the facility. The governing body shall maintain a copy of the approved equivalence issued by the Division.

(8) Where rules, codes, or standards have a conflict, the more stringent requirement shall apply.

History Note: Authority G.S. 131D-2.16; 143B-165;
Temporary Adoption Eff. July 1, 2004;
Eff. July 1, 2005;
Readopted Eff. April 1, 2025.

10A NCAC 13F .0302 DESIGN AND CONSTRUCTION

(a) A building licensed for the first time as an adult care home or a licensed adult care home that is closed or vacant and not serving residents for more than one year for reasons other than approved construction or remodeling shall meet the requirements of the North Carolina State Building Codes for new construction. All new construction, additions, alterations, repairs, modifications, and renovations to existing buildings shall meet the requirements of the North Carolina State Building Codes for I-2 Institutional Occupancy if the facility houses 13 or more residents or the North Carolina State Building Code: Building Code, Large Residential Care Facilities Section if the facility houses seven to twelve residents. The North Carolina State Building Codes, which are incorporated by reference, including subsequent amendments and editions, may be purchased from the International Code Council online at https://shop.iccsafe.org/ at a cost of eight hundred fifty-eight dollars ($858.00) or accessed electronically free of charge at https://codes.iccsafe.org/codes/north-carolina. Licensed facilities shall meet the North Carolina State Building Codes in effect at the time of licensure, construction, or remodeling. The facility shall also meet all of the rules of this Section.

(b) A facility shall not offer services for which the facility was not planned, constructed, equipped, or maintained.

(c) An existing building converted from another use to an adult care home shall meet all requirements of Paragraph (a) of this Rule.

(d) The sanitation, water supply, sewage disposal, and dietary facilities for facilities with a licensed capacity of 13 or more residents shall comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care

Homes and Other Institutions set forth in 15A NCAC 18A .1300, which are hereby incorporated by reference, including subsequent amendments and editions. The sanitation, water supply, sewage disposal, and dietary facilities for facilities with a licensed capacity of 7 to 12 residents shall comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600, which are hereby incorporated by reference, including subsequent amendments and editions. Copies of these Rules may be accessed online free of charge at https://www.oah.nc.gov/.
(e) The facility shall maintain in the facility and have available for review current sanitation and fire safety inspection reports.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; September 1, 1986; April 1, 1984;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005;
Readopted Eff. April 1, 2025.

10A NCAC 13F .0303 LOCATION
(a) An adult care home shall be in a location approved by local zoning boards.
(b) The facility shall be located so that hazards to the occupants are minimized.
(c) Plans for the building and site are to be reviewed and approved by the Construction Section of the Division of Health Service Regulation prior to licensure.
(d) An adult care home may be located in an existing building or in a building newly constructed specifically for that purpose.
(e) The site of the proposed facility shall be approved by the Division of Health Service Regulation prior to construction and shall:

(1) be accessible by streets, roads and highways and be maintained for motor vehicles and emergency vehicle access;
(2) be accessible to fire fighting and other emergency services;
(3) have a water supply, sewage disposal system, garbage disposal system and trash disposal system approved by the local health department having jurisdiction;
(4) meet all local ordinances and zoning laws; and
(5) be free from exposure to pollutants known to the applicant or licensee.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. January1, 1991; April 1, 1984;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Recodified from Rule .0301 Eff. July 1, 2004;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .0304 PLANS AND SPECIFICATIONS
(a) When construction or remodeling of an adult care home is planned, the adult care licensee or licensee's appointed representative shall submit one copy of construction drawings and specifications to the Division for review and approval. Schematic design drawings and design development drawings may be submitted for review and approval prior to the required submission of construction drawings.
(b) Approval of construction drawings and specifications shall be obtained from the Division prior to licensure. Approval of construction drawings and specifications shall expire one year after the date of approval unless a

building permit for the construction has been obtained prior to the expiration date of the approval of construction drawings and specifications.
(c) If an approval expires, renewed approval shall be issued by the Division, provided revised construction drawings and specifications meeting the rules established in this Section are submitted by the adult care licensee or licensee's appointed representative and reviewed by the Division.
(d) An adult care licensee or licensee's appointed representative shall submit changes made during construction to the Division for review and approval to ensure compliance with the rules established in this Section.
(e) Completed construction or remodeling shall conform to the requirements of this Section including the operation of all building systems and shall be approved in writing by the Division prior to licensure or occupancy.
(f) The adult care licensee or licensee's appointed representative shall notify the Division in writing either by U.S. Mail or e-mail when construction or remodeling is complete.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Temporary Adoption Eff. July 1, 2004;
Eff. July 1, 2005;
Readopted Eff. April 1, 2025.

10A NCAC 13F .0305 PHYSICAL ENVIRONMENT
(a) An adult care home shall provide living arrangements for the residents, the live-in staff, and other live-in persons.
(b) The requirements for a living room and recreational area are:
(1) a living room and recreational area shall be located off a lobby or corridor. For the purpose of this Rule, a "living room" is a space enclosed by walls used for social activities, such as reading, talking or watching television. For the purpose of this Rule, a "recreational area" is a space within the facility that may be opened to adjacent spaces and is designated to be used for social activities, such as reading, talking or watching television;
(2) in buildings with a licensed capacity of 15 or less, there shall be a minimum area of 250 square feet;
(3) in buildings with a licensed capacity of 16 or more, there shall be a minimum of 16 square feet per resident; and
(4) a required living room and recreational area shall have windows with views to the outside. The total gross window area shall not be less than eight percent of the gross floor area of the room. The window shall be openable from the inside and shall have insect-proof screens.
(c) The requirements for the dining room are:
(1) the dining room shall be located off a lobby or corridor. For the purposes of this Rule, a "dining room" is a space enclosed by walls used for eating meals;
(2) in buildings with a licensed capacity of 15 or less, there shall be a minimum of 200 square feet;
(3) in building with a licensed capacity of 16 or more, there shall be a minimum of 14 square feet per resident; and
(4) the required dining room shall have windows with views to the outside. The total gross window area shall not be less than eight percent of the gross floor area of the room. The window shall be openable from the inside and shall have insect-proof screens.
(d) The requirements for the bedroom are:
(1) the number of resident beds set up shall not exceed the licensed capacity of the facility;
(2) live-in staff shall be permitted in facilities with a capacity of 7 to 12 residents provided all of the requirements of Section .0600 of these Rules are met;
(3) there shall be separate bedrooms for any live-in staff and other persons living in the facility. Residents shall not share bedrooms with live-in staff and other live-in non-residents;
(4) live-in staff shall not occupy a licensed bed or live in a licensed bed;
(5) residents shall reside in bedrooms with residents of the same sex unless other arrangements are made with each resident's consent;
(6) only rooms authorized by the Division of Health Service Regulation as bedrooms shall be used for bedrooms;
(7) bedrooms shall be located on an outside wall and off a corridor. A room where access is through a bathroom, kitchen, or another bedroom shall not be approved as a resident's bedroom;

(8) private resident bedrooms shall have not less than 100 square feet of occupiable floor area excluding accessory areas such as vestibules, closets, or wardrobes. For the purpose of this Rule, "private resident bedroom" is a resident bedroom occupied by one resident;

(9) semi-private resident bedrooms shall have not less than 80 square feet of occupiable floor area per bed excluding accessory areas such as vestibules, closets, or wardrobes. For the purpose of this Rule, "semi-private resident bedroom" is a resident bedroom occupied by two residents;

(10) the total number of residents assigned to a bedroom shall not exceed the number authorized by the Division of Health Service Regulation for that particular bedroom;

(11) a bedroom may not be occupied by more than two residents;

(12) resident bedrooms shall be designed to accommodate all required furnishings;

(13) resident bedrooms shall be ventilated with one or more windows which are maintained operable. The window area shall not be less than eight percent of the floor space and be equipped with insect-proof screens. The window opening may be restricted to a six-inch opening to inhibit resident elopement or suicide. The windows shall be low enough to see outdoors from the bed and chair, with a maximum 36 inch sill height; and

(14) Residents' bedrooms shall have one closet or wardrobe per resident. A closet or wardrobe shall have clothing storage space of not less than 48 cubic feet per bed, approximately two feet deep by three feet wide by eight feet high, of which one-half of this space shall be for hanging with an adjustable height hanging bar.

(e) The requirements for bathrooms, toilet rooms, bathtubs, showers, a manufactured walk-in tub, or a similar manufactured bathtub, and central bathing rooms are:

(1) minimum bathroom and toilet rooms shall include a toilet and a hand lavatory for each 5 residents, and a bathtub, shower, a manufactured walk-in tub, or a similar manufactured bathtub for each 10 residents or portion thereof. The hand lavatory shall be trimmed with valves that can be operated without hands. If the hand lavatory is equipped with blade handles, the blade handles shall not be less than four and one half inches in length. If the hand lavatory faucet depends on the building electrical service for operation, the faucet must have an emergency power source or battery backup capability. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;

(2) entrance to bathrooms and toilet rooms shall not be through a kitchen, another person's bedroom, or another bathroom;

(3) toilet rooms and bathrooms for staff and visitors shall be in accordance with the North Carolina State Building Code: Plumbing Code;

(4) bathrooms and toilet rooms accessible to the physically handicapped shall be provided as required by the North Carolina State Building Codes;

(5) bathrooms and toilet rooms shall be designed to provide privacy. Bathrooms and toilet rooms with two or more toilets shall have privacy partitions or curtains for each toilet. Each bathtub, shower, a manufactured walk-in tub, or a similar manufactured bathtub shall have privacy partitions or curtains. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities;

(6) hand grips shall be installed at all toilets, bathtubs, showers, a manufactured walk-in tub, and similar manufactured bathtubs;

(7) there shall be one central bathing room opening off the corridor in a facility. In multi-level facilities, each resident floor shall contain a minimum of one central bathing room opening off the corridor. Central bathing room(s) shall have the following:

(A) a door of three feet minimum width;

(B) a roll-in shower designed to allow the staff to help a resident in taking a shower without the staff getting wet. The roll-in shower shall be designed and equipped for unobstructed ease of shower chair entry and use. If a bathroom with a roll-in shower designed and equipped for unobstructed ease of shower chair entry adjoins each resident bedroom in the facility, the central bathing area is not required to have a roll-in shower;

(C) a bathtub, a manufactured walk-in tub, or a similar manufactured bathtub designed for easy transfer of residents into the tub. Bathtubs shall be accessible on three sides. Manufactured walk-in tubs or a similar manufactured bathtub shall be accessible on at least two sides. Staff shall not be required to reach over or through the tub faucets and other fixture fittings to assist the resident in the tub;

(D) a toilet and a lavatory trimmed with valves that can be operated without hands. If the lavatory is equipped with blade handles, the blade handles shall not be less than four and one half inches in length. If the lavatory faucet depends on the building electrical service for operation, the faucet shall have an emergency power source or battery backup capability. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets; and

(E) individual cubicle curtain enclosing each toilet, bathtub, shower, manufactured walk-in tub, or a similar manufactured bathtub and shower. A closed cubicle curtain at one of these plumbing fixtures shall not restrict access to the other plumbing fixtures.

(8) where the tub and shower are in separate rooms, each room shall have a lavatory and a toilet. The lavatory shall be trimmed with valves that can be operated without hands. If the lavatory is equipped with blade handles, the blade handles shall not be less than four and one half inches in length. If the lavatory faucet depends on the building electrical service for operation, the faucet must have an emergency power source or battery backup capability. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;

(9) in facilities where resident bedrooms do not have direct access to a bathroom or toilet room, bathrooms and toilet rooms shall be evenly distributed throughout the facility for residents' use;

(10) resident toilet rooms and bathrooms shall not be used for storage or other purposes;

(11) toilet rooms and bathrooms shall be well lighted;

(12) toilet rooms and bathrooms shall have an exhaust system per the North Carolina State Building Codes. Exhaust vents shall be vented directly to the outdoors;

(13) nonskid surfacing or strips shall be installed in showers, bath areas, and bathtubs; and

(14) the floors of the bathrooms and toilet rooms shall be water-resistant and slip-resistant.

(f) The requirements for storage rooms and closets are:

(1) a facility shall have a minimum area of five square feet (40 cubic feet) per licensed capacity for general storage for the facility. This storage space shall be either in the facility or within 500 feet of the facility on the same site;

(2) separate storage room or area shall provide for the storage of clean linens. Clean linens shall not be stored in the same room or area as soiled linens;

(3) separate storage room shall provide for the storage of soiled linens. Access to soiled linen storage shall be from a corridor or laundry room. If space for the storage of soiled linen is provided in the soiled utility room, a separate soiled linen room is not required;

(4) there shall be space for the storage of dry, refrigerated, and frozen food items, and shall comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300, which is incorporated by reference including subsequent amendments and editions, for facilities with a licensed capacity of 13 or more residents, and Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600, which is incorporated by reference including subsequent amendments and editions, for facilities with a licensed capacity of 7 to 12 residents;

(5) the requirements for housekeeping storage are:

(A) a housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof. In multi-level facilities, each resident floor shall have a housekeeping closet; and

(B) there shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled, or handled. Cleaning supplies shall be monitored while in use;

(6) there shall be a sink which can be operated without the use of hands located adjacent to the drug storage area. If the sink is equipped with blade handles, the blade handles shall not be less than four and one half inches in length. If the sink faucet depends on the building electrical service for operation, the faucet must have battery backup capability or an emergency power source. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;

(7) the facility shall have locked storage for residents' personal articles within the facility; and

(8) the facility shall have some means for staff to lock personal articles within the facility.

(g) The requirements for corridors are:
(1) doors to spaces other than reach-in closets shall not swing into the corridor;
(2) handrails shall be provided on both sides of corridors at 36 inches above the floor and be capable of supporting a 250 pound concentrated load;
(3) corridors shall be lighted with night lights providing 1 foot-candle power at the floor; and
(4) corridors shall be free of all equipment and other obstructions.

(h) The requirements for outside entrances and exits are:
(1) service entrances shall not be through resident use areas;
(2) all steps, porches, stoops, and ramps shall have handrails and guards. Handrails shall be on both sides of steps and ramps including sides bordered by the facility wall. Handrails shall extend the full length of steps and ramps. Guards shall be on all open sides of steps, porches, stoops, and ramps. For the purposes of this Rule, "guards" are rails or barriers located at or near the open side of elevated walking surfaces that minimizes the possibility of a fall from a walking surface to any adjacent change in elevation;
(3) all exit door locks shall operate from the inside at all times by a single hand motion without keys, tools or special knowledge; and
(4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities.

(i) The requirements for floors are:
(1) all floors shall be of smooth, non-skid material and so constructed as to be easily cleanable;
(2) scatter or throw rugs shall not be used; and
(3) all floors shall be kept in good repair.

(j) The requirements for soiled utility rooms are:
(1) for facilities with a licensed capacity of 13 or more residents, a separate soiled utility room shall be provided and equipped for the cleaning and sanitizing of bed pans as required by 15A NCAC 18A .1312, which is incorporated by reference including subsequent amendments and editions. The soiled utility room shall have a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four and one half inches in length. If the sink faucet depends on the building electrical service for operation, the faucet must have battery backup capability or an emergency power source. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets; and
(2) for facilities with a licensed capacity of 7 to 12 residents, a separate soiled utility room shall be provided and equipped for the cleaning and sanitizing of bed pans. The soiled utility room shall have a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four and one half inches in length. If the sink faucet depends on the building electrical service for operation, the faucet must have battery backup capability or an emergency power source. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets.

(k) The facility shall have an area within the facility large enough to accommodate normal administrative functions.

(l) The requirements for laundry facilities are:
(1) laundry facilities shall be large enough to accommodate washers, dryers, and ironing equipment or work tables;
(2) these facilities shall be located where soiled linens will not be carried through the kitchen, dining, clean linen storage, living rooms or recreational areas; and
(3) a minimum of one residential type washer and dryer each shall be provided in a separate room that is accessible by staff, residents, and family, even if all laundry services are contracted. In multi-level facilities, each resident floor shall have a minimum of one residential type washer and dryer each in a separate room which is accessible by staff, residents, and family.

(m) The requirements for outside premises are:

(1) the outside grounds of new and existing facilities shall be maintained in a clean and safe condition. For the purpose of this Rule, "clean and safe condition" means free from debris, trash, uneven surfaces, and similar conditions as not to attract rodents and vermin and provide for safe movement throughout facility grounds. Creeks, ravines, ponds, pools, and other similar areas shall have safety protection. For the purpose of this Rule, "safety protection" means preventive measures, such as barriers, to block access to such areas;
(2) if the facility has a fence around the premises, the fence shall not prevent residents from exiting or entering freely or have sharp edges, rusting posts, or other similar conditions that may cause injury; and
(3) outdoor walkways and drives shall be illuminated by no less than five foot-candles of light at ground level.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1987; July 1, 1984; April 1, 1984;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Recodified from 10A NCAC 13F .0303 Eff. July 1, 2004;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005;
Readopted Eff. April 1, 2025.

10A NCAC 13F .0306 HOUSEKEEPING AND FURNISHINGS

(a) Adult care homes shall:
(1) have walls, ceilings, and floors or floor coverings that are clean, safe, and functional;
(2) have no persistent and recurring odors that are considered by the residents to be unpleasant;
(3) have furniture that is clean, safe, and functional;
(4) have a sanitation report in accordance with one of the following:
(A) a North Carolina Department of Health and Human Services, Division of Public Health, Environmental Health Section approved sanitation classification at all times in facilities with 12 beds or less, pursuant to the "Rules Governing the Sanitation of Residential Care Facilities", 15A NCAC 18A .1600, which are incorporated by reference including all subsequent amendments and can be accessed electronically free of charge at http://ehs.dph.ncdhhs.gov/rules.htm; and
(B) a North Carolina Department of Health and Human Services Division of Public Health, and Environmental Health Section sanitation scores of 85 or above at all times in facilities with 13 beds or more. The "Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes, and Other Institutions", 15A NCAC 18A .1300, can be accessed electronically free of charge at http://ehs.dph.ncdhhs.gov/rules.htm.
(5) be maintained in an uncluttered, clean, and orderly manner, free of all obstructions and hazards;
(6) have a supply available in the facility at all times of bath soap, clean towels, washcloths, sheets, pillowcases, blankets, and additional covers such as a bedspread, comforter, or quilt for each resident to use;
(7) make available the following items as needed at no additional charge to the personal funds of recipients of State-County Special Assistance:
(A) protective mattress covers, and clean, absorbent, soft, and smooth mattress pads;
(B) bedpans and urinals; and
(C) bedside commodes, walkers, and wheelchairs.
(8) have one television and one radio, in good working order;
(9) have curtains, draperies, or blinds at windows in resident use areas to provide for resident privacy;
(10) have recreational equipment, supplies for games, books, magazines, and a current newspaper available for residents;
(11) have a clock that has numbers at least 1½ inches tall in the living room, the dining room, or dining area; and
(12) have at least one telephone that does not require electricity or cellular service to operate.

(b) Each bedroom shall have the following furnishings in good repair and clean for each resident:

(1) a bed equipped with a box spring and mattress or a bed frame with solid link springs with a foam mattress or a mattress designed to prevent sagging. A hospital bed equipped with all accessories required for use shall be arranged for as needed. A waterbed is allowed if requested by a resident and permitted by the facility. Each bed shall have the following:
  (A) at least one pillow with clean pillowcase;
  (B) a clean top and bottom sheet on the bed, with bed changed at least once a week and when soiled; and
  (C) clean bedspread and other clean coverings as needed.
(2) a bedside type table;
(3) chest of drawers or bureau when not provided as built-ins, or a double chest of drawers or double dresser for two residents;
(4) a wall or dresser mirror that may be used by each resident in each bedroom;
(5) a minimum of one chair that is comfortable as preferred by the resident, which may include a rocking or straight chair, with or without arms, that is high enough for the resident to easily rise without discomfort;
(6) additional chairs available, as needed, for use by visitors;
(7) individual clean towel, wash cloth, and towel bar in the bedroom or an adjoining bathroom; and
(8) a light overhead of bed with a switch within reach of person lying on bed; or a lamp. The light shall provide a minimum of 30 foot-candle power of illumination for reading.

(c) The living room shall have living room furnishings that are in good working order and provide comfort as preferred by residents with coverings that are easily cleanable.

(d) The dining room shall have the following furnishings:

(1) small tables serving from two to eight persons and chairs to seat all residents eating in the dining room; tables and chairs equal to the resident capacity of the home shall be on the premises; and
(2) chairs that are sturdy, without rollers unless retractable or on front legs only, non-folding and designed to minimize tilting.

(e) Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1987; April 1, 1984;
Temporary Amendment Eff. September 1, 2003.
Amended Eff. June 1, 2004;
Recodified from 10A NCAC 13F .0304 Eff. July 1, 2004;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005;
Readopted Eff. April 1, 2025.

10A NCAC 13F .0307 FIRE ALARM SYSTEM

(a) The fire alarm system in adult care homes shall be able to transmit the fire alarm signal automatically to the local emergency fire department dispatch center that is legally committed to serving the area in which the facility is located. The alarm shall be transmitted either to a fire department or through a third-party service that shall transmit the alarm to the fire department. The method used to transmit the alarm shall be in accordance with local ordinances.

(b) The facility shall comply with fire safety requirements of the city and county in which the facility is located as required by local building and fire officials.

(c) In a facility licensed before April 1, 1984 and constructed prior to January 1, 1975, the building, in addition to meeting the requirements of the North Carolina State Building Code in effect at the time the building was constructed, shall have the following:

(1) A fire alarm system with pull stations within five feet of an exit and sounding devices which are audible throughout the building;
(2) Products of combustion (smoke) U/L listed detectors in all corridors. The detectors shall be no more than 60 feet from each other and no more than 30 feet from an end wall;

(3) Heat detectors or products of combustion detectors in all storage rooms, kitchens, living rooms, dining rooms and laundries;
(4) All detection systems interconnected with the fire alarm system; and
(5) Emergency power for the fire alarm system, heat detection system, and products of combustion detection with automatic start generator or trickle charge battery system capable of operating the fire alarm systems for 24 hours and able to sound the alarm for five minutes at the end of that time. Emergency egress lights and exit signs shall be powered from an automatic start generator or a U/L approved trickle charge battery system capable of operation for 1-1/2 hours when normal power fails.

(d) When a facility not equipped with a complete automatic fire extinguishment system replaces the fire alarm system, all bedrooms shall have smoke detectors. Other building spaces shall provide fire detection devices as required by the North Carolina State Building Code and requirements of this Subchapter.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Recodified from 10A NCAC 13F .0305 Eff. July 1, 2004;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005;
Readopted Eff. April 1, 2025.

10A NCAC 13F .0308 FIRE EXTINGUISHERS

(a) At least one five pound or larger (net charge) A-B-C type fire extinguisher is required for each 2,500 square feet of floor area or fraction thereof.

(b) One five pound or larger (net charge) A-B-C or CO/2 type is required in the kitchen and, where applicable, in the maintenance shop.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1987; April 1, 1984;
Recodified from Rule .0306 Eff. July 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .0309 PLAN FOR EVACUATION

(a) A written fire evacuation plan (including a diagrammed drawing) which has the written approval of the local Code Enforcement Official shall be prepared in large print and posted in a central location on each floor of an adult care home. The plan shall be reviewed with each resident on admission and shall be a part of the orientation for all new staff.

(b) There shall be rehearsals of the fire plan quarterly on each shift in accordance with the requirement of the local Fire Prevention Code Enforcement Official.

(c) Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, the shift, staff members present, and a short description of what the rehearsal involved.

(d) A written disaster plan, which has the written approval of or has been documented as submitted to the local emergency management agency and the local agency designated to coordinate special needs sheltering during disasters, shall be prepared and updated at least annually and shall be maintained in the facility.

(e) A facility that elects to be designated as a special care shelter during an impending disaster or emergency event shall follow the guidelines established by the latest Division of Social Services' State of North Carolina Disaster Plan which is available at no cost from the N.C. Division of Social Services, 2401 Mail Service Center, Raleigh, NC 27699-2401. The facility shall contact the Division of Health Service Regulation to determine which licensure rules may be waived according to G.S. 131D-7 to allow for emergency care shelter placements prior to sheltering during the emergency event.

(f) This Rule shall apply to new and existing facilities.

History Note: Authority G.S. 131D.2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1987; April 1, 1984;
Recodified from Rule .0307 Eff. July 1, 2004;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005.

10A NCAC 13F .0310 ELECTRICAL OUTLETS

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Recodified from 10A NCAC 13F .0308 Eff. July 1, 2004;
Temporary Amendment July 1, 2004;
Amended Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;
Repealed Eff. April 1, 2025.

10A NCAC 13F .0311 OTHER REQUIREMENTS

(a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition.

(b) The following shall apply to heaters and cooking appliances:

(1) built-in electric heaters, if used, shall be installed or protected so as to avoid burn hazards to residents and room furnishings;

(2) unvented fuel burning room heaters and portable electric heaters are prohibited;

(3) fireplaces, fireplace inserts, and wood stoves shall be designed and installed so as to avoid a burn hazard to residents. Fireplace inserts and wood stoves shall be U.L. listed;

(4) the power supply for ovens, ranges, microwaves, cook tops, and other domestic cooking appliances located in resident activity or recreational areas shall have a locking feature provided that shall be controlled by staff. These appliances shall not be used except under facility staff supervision;

(5) the power supply for ovens, ranges, microwaves, cook tops, and other domestic cooking appliances located in resident rooms shall have a locking feature provided that shall be controlled by staff. Each resident shall be assessed by the administrator or their designee to determine the resident's capability to operate the appliances in a safe manner, and the degree of staff supervision necessary to ensure safe operation of the appliances.

(c) The facility shall have heating and cooling systems such that environmental temperature controls shall be capable of maintaining temperatures in the facility at 75 degrees F minimum in the heating season, and not exceed 80 degrees F during the non-heating season.

(d) The hot water system shall supply hot water to the kitchen, bathrooms, laundry, housekeeping closets, and soiled utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities.

(e) Multi-story facilities shall be equipped with elevators.

(f) In addition to the required emergency lighting, minimum lighting shall be as follows:

(1) 30 foot-candle power for reading; and

(2) 10 foot-candle power for general lighting.

(g) The spaces listed in this Paragraph shall have an exhaust system per the North Carolina State Building Code. Exhaust vents shall be vented directly to the outdoors:

(1) soiled linen storage;

(2) soiled utility room;

(3) bathrooms and toilet rooms;

(4) housekeeping closets; and
(5) laundry area.

(h) In facilities licensed for 7 to 12 residents, there shall be an electrically operated call system meeting the following requirements:

(1) the call system shall connect residents' bedrooms and bathrooms to the live-in staff bedroom. Where there are no live-in staff for the facility, the call system shall connect residents' bedrooms and bathrooms to a location accessible to staff;
(2) residents' bedrooms shall have a resident call system activator at the resident's bed;
(3) the resident call system activator shall be within reach of a resident lying on the bed;
(4) the resident call system activator shall be such that it can be activated with a single action and remain on until deactivated by staff at point of origin; and
(5) when activated, the call system shall activate an audible and visual signal in the live-in staff bedroom, in a location accessible to staff, or register with the floor staff.

(i) In licensed facilities without live-in staff, there shall be an electrically operated call system meeting the following requirements:

(1) the call system shall connect residents' bedrooms and bathrooms to a location accessible to staff;
(2) residents' bedrooms shall have a resident call system activator at the resident's bed;
(3) the resident call system activator shall be within reach of a resident lying on the bed;
(4) the resident call system activator shall be such that it can be activated with a single action and remain on until deactivated by staff at point of origin; and
(5) when activated, the call system shall activate an audible and visual signal in a location accessible to staff.

(j) Except where otherwise specified, existing facilities housing persons unable to evacuate without staff assistance shall provide those residents with hand bells or other signaling devices.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1987; April 1, 1984;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Recodified from 10A NCAC 13F .0309 Eff. July 1, 2004;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005;
Readopted Eff. April 1, 2025.

10A NCAC 13F .0312 BUILDING CODE AND SANITATION REQUIREMENTS

History Note: Authority G.S. 131D-2; 143B-165; S.L .2002-0160; 2003-0284;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Recodified from Rule .0310 Eff. July 1, 2004;
Temporary Repeal Eff. July 1, 2004;
Repealed Eff. July 1, 2005.

SECTION .0400 - STAFF QUALIFICATIONS

10A NCAC 13F .0401 CERTIFICATION OF ADMINISTRATOR (TRANSFERRED TO 10A NCAC 13F .1701)

10A NCAC 13F .0402 QUALIFICATIONS OF MANAGER

The facility shall designate a manager when the administrator is absent from the facility. The manager, is responsible for carrying out the day-to-day operations of an adult care home in the absence of the administrator. The administrator remains ultimately responsible for the adult care home, and the manager shall serve under the direction and supervision of the administrator. The manager shall meet the following requirements:

(1) be 21 years or older;

(2) be a high school graduate or certified under the G.E.D. program, or if hired before September 1, 2024, have passed the alternative examination established by the Department;

(3) have six months training or experience related to management or supervision in long term care or health care settings or be a licensed health professional such as a mental health professional, nurse practitioner, physician assistant, or registered nurse, a nursing home administrator certified pursuant to G.S. 90-276(4), or an assisted living administrator certified pursuant to G.S. 90-288.14; and

(4) earn 12 hours a year of continuing education credits in the management of adult care homes or care of the elderly and individuals with physical, intellectual, or developmental disabilities, cognitive impairment, and mental illness.

History Note: *Authority G.S. 131D.2.16; 131D-4.5; 131D-25; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Readopted Eff. September 1, 2024.

10A NCAC 13F .0403 QUALIFICATIONS OF MEDICATION STAFF

(a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement.

(b) Medication aides and their direct supervisors, except persons authorized by state occupational licensure laws to administer medications, shall complete six hours of continuing education annually related to medication administration.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 131D-4.5B; 143B-165;*
Temporary Adoption Eff. January 1, 2000; December 1, 1999;
Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005;
Readopted Eff. July 1, 2021.

10A NCAC 13F .0404 QUALIFICATIONS OF ACTIVITY DIRECTOR

Adult care homes shall have an activity director who meets the following qualifications:

(1) The activity director hired after September 30, 2022 shall meet a minimum educational requirement by being a high school graduate or certified under the GED Program.

(2) The activity director hired after September 30, 2022 shall complete, within nine months of employment or assignment to this position, the basic activity course for assisted living activity directors offered by community colleges or a comparable activity course as determined by the Department based on instructional hours and content. An activity director shall be exempt from the required basic activity course if one or more of the following applies:

   (a) be a licensed recreational therapist or be eligible for certification as a therapeutic recreation specialist as defined by the North Carolina Recreational Therapy Licensure Act in accordance with G.S. 90C;

   (b) have two years of experience working in programming for an adult recreation or activities program within the last five years, one year of which was full-time in an activities program for patients or residents in a health care or long term care setting;

   (c) be a licensed occupational therapist or licensed occupational therapy assistant in accordance with G.S. 90, Article 18D;

   (d) be certified as an Activity Professional by the National Certification Council for Activity Professionals; or

   (e) the required basic activity course was completed prior to September 1, 2024.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1987; April 1, 1984;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005;
Readopted Eff. October 1, 2022;
Amended Eff. September 1, 2024.

10A NCAC 13F .0405 QUALIFICATIONS OF FOOD SERVICE SUPERVISOR

Each facility shall have a food service supervisor that is experienced in food service in commercial, healthcare, or congregate care settings who shall consult with a licensed dietitian/nutritionist as necessary to meet the dietary needs of the residents in accordance with Rule .0904 of this Subchapter.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1987; April 1, 1984;
Readopted Eff. February 1, 2022.

10A NCAC 13F .0406 TEST FOR TUBERCULOSIS

(a) Upon employment or moving into an adult care home, the administrator, all other staff, and any persons living in the adult care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments.
(b) There shall be documentation on file in the adult care home that the administrator, all other staff, and any persons living in the adult care home are free of tuberculosis disease.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. September 1, 2003; July 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;
Amended Eff. July 1, 2021.

10A NCAC 13F .0407 OTHER STAFF QUALIFICATIONS

(a) Each staff person at an adult care home shall:
(1) have a job description that reflects the position's duties and responsibilities and is signed by the administrator and the employee;
(2) be able to implement all of the adult care home's accident, fire safety, and emergency procedures for the protection of the residents;
(3) be informed of the confidential nature of resident information and shall protect and preserve the information from unauthorized use and disclosure, in accordance with G.S. 131D-21(6) and 131D-21.1;
(4) not hinder or interfere with the exercise of the rights guaranteed under the Declaration of Residents' Rights in G.S. 131D-21;
(5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;
(6) have documented annual immunization against influenza virus according to G.S. 131D-9, and exceptions as provided in the law shall be documented in the staff person's personnel record;

(7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file;
(8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file;
(9) maintain a current driver's license if responsible for transportation of residents; and
(10) be willing to cooperate with state and local inspectors when determining and maintaining compliance with the rules of this Subchapter.

(b) At all times, there shall be at least one staff person in the facility in charge of resident care who shall be 18 years or older.

(c) If licensed practical nurses are employed by the facility and practicing in their licensed capacity as governed by the North Carolina Board of Nursing, there shall be a registered nurse available in accordance with the rules set forth in 21 NCAC 36 .0224 and 21 NCAC 36 .0225, which are hereby incorporated by reference including subsequent amendments.

History Note: *Authority G.S. 131D-2.16; 131D 4.5(4); 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Temporary Amendment Eff. September 1, 2003; July 1, 2003.
Amended Eff. June 1, 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13F .0408 QUALIFICATIONS OF PERSONAL CARE AIDE SUPERVISOR

(a) Facilities with a census of 31 or more residents shall employ a Personal Care Aide Supervisor as defined in Paragraph (b) of this Rule. The term "Supervisor" as used throughout Section .0600 of this Subchapter refers to the Personal Care Aide Supervisor.

(b) A supervisor shall meet the following qualifications:
(1) be 21 years or older;
(2) be a high school graduate or certified under the G.E.D. program or if hired before September 1, 2024, have passed an alternative examination established by the Department;
(3) meet the health requirements according to Rule .0406 of this Section;
(4) have six months of experience in performing or supervising the performance of the duties to be supervised during the period of three years prior to July 1, 2000 or the date of hire, whichever is later, or be a licensed health professional such as a mental health professional, nurse practitioner, physician assistant, or registered nurse, or a nursing home administrator certified pursuant to G.S. 90-276(4);
(5) meet the same minimum training and competency requirements of the aides being supervised; and
(6) earn 12 hours a year of continuing education credits related to the care of the elderly and individuals with physical, intellectual, or developmental disabilities, cognitive impairment, and mental illness.

History Note: *Authority G.S. 131D-2.16; 131D-4.3; 143B-165;*
Eff. September 1, 2024.

SECTION .0500 - STAFF ORIENTATION, TRAINING, COMPETENCY AND CONTINUING EDUCATION

10A NCAC 13F .0501 PERSONAL CARE TRAINING AND COMPETENCY

(a) The facility shall assure that staff who provide or directly supervise staff who provide personal care to residents complete an 80-hour personal care training and competency evaluation program established by the Department. For the purpose of this Rule, "directly supervise" means being on duty in the facility to oversee or direct the performance of staff duties. A copy of the 80-hour training and competency evaluation program is available online at https://info.ncdhhs.gov/dhsr/acls/training/index.html#80hr, at no cost. The 80-hour personal care training and competency evaluation program curriculum shall include:
(1) observation and documentation skills;
(2) basic nursing skills, including special health-related tasks;

(3) activities of daily living and personal care skills;
(4) cognitive, behavioral, and social care;
(5) basic restorative services; and
(6) residents' rights as established by G.S. 131D-21.

(b) The facility shall assure that training specified in Paragraph (a) of this Rule is completed within six months after hiring for staff hired after September 30, 2022. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review by the Division of Health Service Regulation and the county department of social services.

(c) The facility shall assure that staff who perform or directly supervise staff who perform personal care receive training and supervision on the performance of individual job assignments prior to meeting the training and competency requirements of this Rule. Documentation of training shall be maintained in the facility and available for review by the Division of Health Service Regulation and the county department of social services.

(d) The Department shall exempt staff from the 80-hour training and competency evaluation program who are:
(1) licensed health professionals;
(2) listed on the Nurse Aide Registry; or
(3) documented as having completed one of the following previously approved training programs:
(A) a 40-hour or 75-hour training and competency evaluation program prior to July 1, 2000; or
(B) a 45-hour or 80-hour training and competency evaluation program for training exemption from July 1, 2000 through August 31, 2003.

History Note: Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 143B-165;
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13F .0502 PERSONAL CARE TRAINING CONTENT AND INSTRUCTORS

History Note: Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 143B-165;
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;
Repealed Eff. October 1, 2022.

10A NCAC 13F .0503 MEDICATION ADMINISTRATION COMPETENCY

(a) The competency evaluation for medication administration required in Rule .0403 of this Subchapter shall consist of a written examination and a clinical skills validation to determine competency in the following areas:
(1) medical abbreviations and terminology;
(2) transcription of medication orders;
(3) obtaining and documenting vital signs;
(4) procedures and tasks involved with the preparation and administration of oral (including liquid, sublingual and inhaler), topical (including transdermal), ophthalmic, otic, and nasal medications;
(5) infection control procedures;
(6) documentation of medication administration;
(7) monitoring for reactions to medications and procedures to follow when there appears to be a change in the resident's condition or health status based on those reactions;
(8) medication storage and disposition;

(9) rules pertaining to medication administration in adult care facilities; and
(10) the facility's medication administration policy and procedures.

(b) An individual shall score at least 90% on the written examination which shall be a standardized examination established by the Department.

(c) Verification of an individual's completion of the written examination and results can be obtained at no charge on the North Carolina Adult Care Medication Aide Testing website at https://mats.ncdhhs.gov/test-result.

(d) The clinical skills validation portion of the competency evaluation shall be conducted by a registered nurse or a licensed pharmacist who has a current unencumbered license in North Carolina. The registered nurse or licensed pharmacist shall conduct a clinical skills validation for each medication administration task or skill that will be performed in the facility. Competency validation by a registered nurse is required for unlicensed staff who perform any of the personal care tasks related to medication administration listed in Subparagraphs (a)(4), (a)(7), (a)(11), (a)(14), and (a)(15) as specified in Rule .0903 of this Subchapter.

(e) The Medication Administration Skills Validation Form shall be used to document successful completion of the clinical skills validation portion of the competency evaluation for those medication administration tasks to be performed in the facility employing the medication aide. The form requires the following:

(1) name of the staff and adult care home;
(2) satisfactory completion date of demonstrated competency of task or skill with the instructor's initials or signature;
(3) if staff needs more training on skills or tasks, it should be noted with the instructor's signature; and
(4) staff and instructor signatures and date after completion of tasks.

Copies of this form and instructions for its use may be obtained at no cost on the Adult Care Licensure website, https://info.ncdhhs.gov/dhsr/acls/pdf/medchklst.pdf. The completed form shall be maintained and available for review in the facility and is not transferable from one facility to another.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. January 1, 2000; December 1, 1999;
Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13F .0504 COMPETENCY EVALUATION AND VALIDATION FOR LICENSED HEALTH PROFESSIONAL SUPPORT TASKS

(a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task.

(b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident.

(c) Evaluation and validation of competency shall be performed by the following licensed health professionals in accordance with his or her North Carolina occupational licensing laws:

(1) A registered nurse shall validate the competency of staff who perform any of the personal care tasks specified in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter;
(2) In lieu of a registered nurse, a licensed respiratory care practitioner may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(6), (a)(11), (a)(16), (a)(18), (a)(19), and (a)(21) of Rule .0903 of this Subchapter;
(3) In lieu of a registered nurse, a licensed pharmacist may validate the competency of staff who perform the personal care tasks specified in Subparagraph (a)(8) and (a)(11) of Rule .0903 of this Subchapter. An immunizing pharmacist may validate the competency of staff who perform the personal care task specified in Subparagraph (a)(15) of Rule .0903 of this Subchapter; and
(4) In lieu of a registered nurse, an occupational therapist or physical therapist may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(17) and (a)(22) through (a)(27) of Rule .0903 of this Subchapter.

(d) If a physician certifies that care can be provided to a resident in an adult care home on a temporary basis in accordance with G.S. 131D-2.2(a), the facility shall ensure that the staff performing the care task(s) authorized by

the physician are competent to perform the task(s) in accordance with Paragraphs (b) and (c) of this Rule. For the purpose of this Rule, "temporary basis" means a length of time as determined by the resident's physician to meet the care needs of the resident and prevent the resident's relocation from the adult care home.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. September 1, 2003;
Eff. July 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;
Amended Eff. October 1, 2022; July 1, 2021.

10A NCAC 13F .0505 TRAINING ON CARE OF DIABETIC RESIDENTS

An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows:

(1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner.
(2) Training shall include at least the following:
  (a) basic facts about diabetes and care involved in the management of diabetes;
  (b) insulin action;
  (c) insulin storage;
  (d) mixing, measuring and injection techniques for insulin administration;
  (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms;
  (f) blood glucose monitoring; universal precautions;
  (g) universal precautions;
  (h) appropriate administration times; and
  (i) sliding scale insulin administration.

History Note: Authority 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. September 1, 2003;
Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .0506 TRAINING ON PHYSICAL RESTRAINTS

(a) An adult care home shall assure that all staff responsible for caring for residents with medical symptoms that warrant restraints are trained on the use of alternatives to physical restraint use and on the care of residents who are physically restrained.
(b) Training shall be provided by a registered nurse and shall include the following:

(1) alternatives to physical restraints;
(2) types of physical restraints;
(3) medical symptoms that warrant physical restraint;
(4) negative outcomes from using physical restraints;
(5) correct application of physical restraints;
(6) monitoring and caring for residents who are restrained; and
(7) the process of reducing restraint time by using alternatives.

History Note: Authority 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. September 1, 2003;
Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .0507 TRAINING ON CARDIO-PULMONARY RESUSCITATION

Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American

Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation.

History Note: *Authority 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. September 1, 2003;
Eff. June 1, 2004;
Amended Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .0508 ASSESSMENT TRAINING

The person or persons designated by the administrator to perform resident assessments as required by Rule .0801 of this Subchapter shall read the Resident Assessment Self-Instructional Manual for Adult Care Homes established by the Department and certify completion by signature on the last page of the manual before performing the required resident assessments. Registered nurses are exempt from this requirement. The Resident Assessment Self-Instructional Manual for Adult Care Homes is herein incorporated by reference including subsequent amendments and editions and is available on the Adult Care Licensure website, https://info.ncdhhs.gov/dhsr/acls/pdf/assessmentmanual.pdf, at no cost.

History Note: *Authority G.S. 131D-2.15; 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. September 1, 2003;
Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;
Amended Eff. October 1, 2022; April 1, 2022.

10A NCAC 13F .0509 FOOD SERVICE ORIENTATION

(a) The food service supervisor and adult care home dietary staff who prepare and serve food shall complete a food service orientation training that provides an overview of food service in adult care homes, including the preparation of therapeutic diets, established by the Department or an equivalent that contains at least the same information as required in the training approved by the Department within 30 days of hire. The food service orientation training is available at https://info.ncdhhs.gov/dhsr/acls/pdf/foodsrvman.pdf, at no cost.
(b) Licensed dietitian/nutritionists are exempt from this orientation.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;
Amended Eff. January 1, 2022.

10A NCAC 13F .0510 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13F .0511 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13F .0512 DOCUMENTATION OF TRAINING AND COMPETENCY VALIDATION

An adult care home shall maintain documentation of the training and competency validation of staff required by the rules of this Section in the facility and available for review.

History Note: *Authority 131D-2.16; 143B-165;*
Temporary Adoption Eff. September 1, 2003;
Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

SECTION .0600 - STAFFING

10A NCAC 13F .0601 MANAGEMENT OF FACILITIES - GENERAL ADMINISTRATOR AND MANAGER RESPONSIBILITIES

(a) Each adult care home shall have an administrator who is certified in accordance with Rule .1701 of this Subchapter. The administrator shall be responsible for the total operation and management of the facility to assure that all care and services are provided to maintain the health, safety, and welfare of the residents in accordance with all applicable local, state, and federal regulations and codes. The administrator shall also be responsible to the Division of Health Service Regulation and the county department of social services for complying with the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term "administrator" also refers to co-administrator where it is used in this Subchapter.

(b) An adult care home manager shall be responsible for carrying out the day-to-day operations and all required duties of an adult care home in the absence of an administrator.

(c) The administrator shall have knowledge of and shall ensure the following:

(1) the investigation and reporting of any allegations of resident abuse, neglect, and exploitation as specified in Rule .1212(d) of this Subchapter;

(2) the investigation and reporting of any suspicion of or allegations of drug diversion as specified in Rule .1008 of this Subchapter;

(3) the reporting of any incidents of resident elopement or when a resident is missing from the facility, as required in Rule .1212(e)(2) and Rule .0906(f)(4) of this Subchapter; and

(4) the investigation and reporting of any incident or accident resulting in the hospitalization or death of a resident, as specified in Rule .1208 and Rule .1212 of this Subchapter.

(d) The administrator shall be made aware when the facility is unable to meet the staffing requirements of this Section.

(e) The administrator shall be made aware any time the facility seeks the assistance of the local law enforcement authority.

(f) For facilities with a census of 7 to 30 residents, the manager or staff person on duty shall immediately notify the administrator of any of the circumstances listed in Paragraphs (c), (d), and (e) of this Rule.

(g) For facilities with a census of 31 or more, the manager or supervisor shall immediately notify the administrator of any of the circumstances listed in Paragraphs (c), (d), and (e) of this Rule.

History Note: *Authority G.S. 131D-2.16; 131D-4.3; 131D-4.4; 131D-4.5; 131D-25; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1987; April 1, 1984;
Temporary Amendment Eff. January 1, 2000; December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. July 1, 2005; June 1, 2004;
Readopted Eff. September 1, 2024.

10A NCAC 13F .0602 MANAGEMENT OF FACILITIES WITH A CAPACITY OR CENSUS OF SEVEN TO THIRTY RESIDENTS

In a facility with a census of greater than seven but less than 31 residents, there shall be one administrator or manager who is directly responsible for assuring that all required duties are carried out in the facility. One or more of the following arrangements shall be used to manage a facility with a census of seven to 30 residents:

(1) the administrator is in the facility or within 500 feet of the facility with a means of two-way telecommunication with the facility at all times;

(2) a manager is in the facility or within 500 feet of the facility with a means of two-way telecommunication with the facility at all times; or

(3) when there is a cluster of licensed facilities, each with a census of 12 or fewer residents, there shall be at least one staff member, either live-in or on a shift basis in each of these facilities. In addition, there shall be at least one administrator or manager who is within 500 feet of each home with a means of two-way telecommunication with each facility at all times and directly responsible for

assuring that all required duties are carried out in each facility. For the purpose of the rules in this Section, "a cluster of licensed facilities" means up to six licensed adult care homes which are under common ownership and are located adjacently on the same site.

History Note: Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 131D-25; 143B-165;
Temporary Adoption Eff. January 1, 2000;
Eff. July 1, 2000;
Readopted Eff. September 1, 2024.

10A NCAC 13F .0603 MANAGEMENT OF FACILITIES WITH A CENSUS OF 31 TO 80 RESIDENTS

Each facility with a census of greater than 30 but less than 81 residents shall:

(1) have an administrator on-call at all times when not in the building; and

(2) have a manager on-duty in the facility when the administrator is not on-duty in the facility. The personal care aide supervisor, as required in Rule .0608 of this Section, may serve simultaneously as the manager.

History Note: Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 131D-25; 143B-165;
Temporary Adoption Eff. January 1, 2000; December 1, 1999;
Eff. July 1, 2000;
Amended Eff. July 1, 2005;
Readopted Eff. September 1, 2024.

10A NCAC 13F .0604 MANAGEMENT OF FACILITIES WITH A CENSUS OF 81 OR MORE RESIDENTS

(a) For an adult care home with a census of 81 or more residents, there shall be an administrator on-duty at the facility at least eight hours per day, five days per week, and shall not serve simultaneously as a personal care aide supervisor or other staff to meet staffing requirements while on duty as an administrator or be an administrator for another adult care home. If there is more than one facility under the same ownership on a contiguous parcel of land or campus setting, and the combined licensed capacity of the facilities is 200 beds or less, there may be one administrator on duty for all the facilities on the campus. The administrator shall not serve simultaneously as a personal care aide supervisor or other staff in this campus setting.

(b) When the administrator is not on-duty, there shall be a manager on-duty. The supervisor may serve simultaneously as the manager if the individual meets the qualifications required in Rule .0402 of this Subchapter. Each facility on a contiguous parcel of land or campus setting, as described in Paragraph (a) of this Rule, shall have a person designated as the manager in the facility when the administrator is not on-duty.

(c) The administrator shall be on-call, at all times when not on-duty.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 131D-25; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. December 1, 1991; September 1, 1990; July 1, 1990; April 1, 1984;
Temporary Amendment Eff. January 1, 2000; December 1, 1999;
Amended Eff. July 1, 2005; July 1, 2000;
Readopted Eff. September 1, 2024.

10A NCAC 13F .0605 GENERAL STAFFING REQUIREMENTS FOR ADULT CARE HOMES

(a) Adult care homes shall staff based on the facility's resident census and provide staffing to meet the care and supervision needs of the residents in accordance with the rules of this Subchapter.

(b) At no time shall residents be left alone without a staff member in the facility.

(c) The facility shall maintain a daily census log which lists current residents by name, room assignment and date of admission, which shall be available for review by the Division of Health Service Regulation and the county departments of social services.

(d) The facility shall post daily staffing information in a location accessible to residents and visitors in accordance with G.S. 131D-4.3(a)(5). The information shall include:

(1) the name and contact information of the administrator and manager;

(2) the number of required supervisors on each shift; and

(3) the number of aides required on each shift.

History Note: Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 143B-165;
Temporary Adoption Eff. January 1, 2000; December 1, 1999;
Eff. July 1, 2000;
Readopted Eff. September 1, 2024.

10A NCAC 13F .0606 STAFFING FOR FACILITIES WITH A CENSUS OF SEVEN TO TWELVE RESIDENTS

(a) In a facility with a census of greater than six but less than 13 residents, there shall be an administrator or manager in the facility or within 500 feet of the facility with a means of two-way telecommunication at all times.
(b) When the administrator or manager is not on-duty, there shall be at least one staff member on-duty on the first and second shifts and at least one staff member available within the building, who need not be on-duty, on third shift. There shall be a call system connecting the bedroom of the available staff member, who may be asleep on the third shift, with each resident's bedroom. If there are residents in the facility who are disoriented or known to have wandering behavior, there shall be at least one staff member on-duty and awake at all times.
(c) When the administrator or manager is on duty on the first or second shifts and available within the facility on third shift, another staff member (i.e., co-administrator, manager or aide) shall be in the building or within 500 feet of the facility with a means of two-way telecommunication at all times.
(d) The administrator shall prepare a plan of operation for each licensed facility specifying the staff involved, their regularly assigned duties and the amount of time estimated to be spent for each duty. There shall be a current plan of operation on file in the facility, available for review by the Division of Health Service Regulation and the county department of social services.
(e) Each facility shall assign at least one staff member per shift to provide personal care services and supervision of residents as needed by the residents. The staff member so assigned shall not perform food service duties during the shift of rendering care services and supervision. The staff member so assigned shall not perform housekeeping duties during the shift of rendering care services and supervision, except:

(1) between the hours of 7:00 a.m. and 9:00 p.m., and then only when the housekeeping duties are incidental to the rendering of care services; and
(2) between the hours of 9:00 p.m. and 7:00 a.m. and then only to the extent that the housekeeping duties do not hinder the assigned staff's duties of care or immediate response to residents, nor impede the assigned staff member's ability to monitor the residents.

(f) There shall be additional staff to provide daily housekeeping and food service duties.
(g) A cluster of facilities, each with capacity or census of 12 or fewer residents, shall comply with the following staffing:

(1) When there is a cluster of up to six licensed facilities located adjacently, there shall be at least one administrator or manager who lives within 500 feet of each of the facilities with a means of two-way telecommunication at all times.
(2) The administrator or manager on-duty shall be directly responsible for assuring that all required daily duties are carried out in each facility.

History Note: Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 143B-165;
Temporary Adoption Eff. January 1, 2000;
Eff. July 1, 2000;
Readopted Eff. September 1, 2024.

10A NCAC 13F .0607 STAFFING FOR FACILITIES WITH A CENSUS OF 13 TO 20 RESIDENTS

(a) In a facility with a census of greater than 12 but less than 21 residents, there shall be an administrator or manager in the facility or within 500 feet of the facility with a means of two-way telecommunication at all times.
(b) When the administrator or manager is not on duty within the facility, there shall be at least one awake staff member on duty on the first, second, and third shifts.
(c) When the administrator or manager is on duty within the facility, another staff member (i.e. co-administrator, manager or aide) shall be in the building or within 500 feet of the facility with a means of two-way telecommunication at all times and available to assist if needed.
(d) Each facility shall assign at least one staff member per shift to provide personal care services and supervision of residents as needed by the residents. The staff member so assigned shall not perform food service duties during the

shift of rendering care services and supervision. The staff member so assigned shall not perform housekeeping duties during the shift of rendering care services and supervision, except;

(1) between the hours of 7:00 a.m. and 9:00 p.m., and then only when the housekeeping duties are incidental to the rendering of care services; and

(2) between the hours of 9:00 p.m. and 7:00 a.m., and then only to the extent that the housekeeping duties do not hinder the assigned staff's duties of care or immediate response to residents, nor impede the assigned staff member's ability to monitor the residents.

(e) There shall be additional staff to provide daily housekeeping and food service duties.

History Note: *Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 143B-165;*
Eff. September 1, 2024.

10A NCAC 13F .0608 STAFFING FOR FACILITIES WITH A CENSUS OF 21 OR MORE RESIDENTS

(a) Each facility with a census of 21 or more residents shall have staff on duty to meet the needs of the residents.

(b) In addition to the requirement in Paragraph (a) of this Rule, each facility with a census of 21 or more residents shall comply with the following staffing requirements:

(1) On first shift and second shift, the total aide duty hours shall be at least:

(A) 16 hours of aide duty for facilities with a census of 21 to 40 residents.
(B) 20 hours of aide duty for facilities with a census of 41 to 50 residents.
(C) 24 hours of aide duty for facilities with a census of 51 to 60 residents.
(D) 28 hours of aide duty for facilities with a census of 61 to 70 residents.
(E) 32 hours of aide duty for facilities with a census of 71 to 80 residents.
(F) 36 hours of aide duty for facilities with a census of 81 to 90 residents.
(G) 40 hours of aide duty for facilities with a census of 91 to 100 residents.
(H) 44 hours of aide duty for facilities with a census of 101 to 110 residents.
(I) 48 hours of aide duty for facilities with a census of 111 to 120 residents.
(J) 52 hours of aide duty for facilities with a census of 121 to 130 residents.
(K) 56 hours of aide duty for facilities with a census of 131 to 140 residents.
(L) 60 hours of aide duty for facilities with a census of 141 to 150 residents.
(M) 64 hours of aide duty for facilities with a census of 151 to 160 residents.
(N) 68 hours of aide duty for facilities with a census of 161 to 170 residents.
(O) 72 hours of aide duty for facilities with a census of 171 to 180 residents.
(P) 76 hours of aide duty for facilities with a census of 181 to 190 residents.
(Q) 80 hours of aide duty for facilities with a census of 191 to 200 residents.
(R) 84 hours of aide duty for facilities with a census of 201 to 210 residents.
(S) 88 hours of aide duty for facilities with a census of 211 to 220 residents.
(T) 92 hours of aide duty for facilities with a census of 221 to 230 residents.
(U) 96 hours of aide duty for facilities with a census of 231 to 240 residents.

(2) On third shift, the total aide duty hours shall be at least:

(A) 8 hours of aide duty for facilities with a census of 21 to 30 residents.
(B) 16 hours of aide duty for facilities with a census of 31 to 60 residents.
(C) 24 hours of aide duty for facilities with a census of 61 to 90 residents.
(D) 32 hours of aide duty for facilities with a census of 91 to 120 residents.
(E) 40 hours of aide duty for facilities with a census of 121 to 150 residents.
(F) 48 hours of aide duty for facilities with a census of 151 to 180 residents.
(G) 56 hours of aide duty for facilities with a census of 181 to 210 residents.
(H) 64 hours of aide duty for facilities with a census of 211 to 240 residents.

(3) If the Department determines the needs of the residents at a facility are not being met by staffing requirements of Paragraph (b) of this Rule, the Department shall require the facility to employ staff to meet the needs of the residents.

(c) The aide shall provide personal care services and supervision needed by the residents.

(d) Aides shall not provide housekeeping duties except:

(1) Between the hours of 7:00 a.m. to 9:00 p.m.:

(A) to prevent an accident or injury;
(B) when occasionally attending to an individual resident housekeeping need; and

(C) when the number of aides on duty exceeds the minimum required by Paragraph (a) of this Rule.

(2) Between the hours of 9:00 p.m. to 7:00 a.m., as long as the housekeeping duties do not:

(A) hinder the aide's care of residents or immediate response to resident calls;

(B) do not disrupt the residents' normal lifestyles and sleeping patterns; and

(C) do not take the aide out of view of where the residents are as the aide shall be prepared to care for the residents since that remains his or her primary duty.

(e) Aides shall not be assigned food service duties except when providing assistance to individual residents who need help with eating and carrying plates, trays, or beverages to residents.

(f) In addition to the staffing required for management and aide duties, there shall be additional staff to perform housekeeping and food service duties.

Note: The following chart illustrates the required aide, supervisory and management staffing requirements for each eight-hour shift in facilities with a census of 21 or more residents according to Rules .0602, .0603, .0604, .0608, and .0609 of this Section.

Census	Position Type	First Shift	Second Shift	Third Shift
21 - 30	Aide	16	16	8
	Supervisor	Not Required	Not Required	Not Required
	Administrator	In the building, or within 500 feet and immediately available.		
31-40	Aide	16	16	16
	Supervisor	8*	8*	In the building, or within 500 feet and immediately available.**
	Administrator	On call		
41-50	Aide	20	20	16
	Supervisor	8*	8*	In the building, or within 500 feet and immediately available.**
	Administrator	On call		
51-60	Aide	24	24	16
	Supervisor	8*	8*	In the building, or within 500 feet and immediately available.**
	Administrator	On call		
61-70	Aide	28	28	24
	Supervisor	8*	8*	4 hours within the facility/4 hours within 500 feet and immediately available.**
	Administrator	On call		
71-80	Aide	32	32	24
	Supervisor	8	8	4 hours within the facility/4 hours within 500 feet and immediately available.**
	Administrator	On call		
81-90	Aide	36	36	24
	Supervisor	8	8	4 hours within the facility/4 hours within 500 feet and immediately available.**
	Administrator	5 days/week: Minimum of 40 hours. When not in facility, on call.		

91-100	Aide	40	40	32
	Supervisor	8	8	8**
	Administrator	5 days/week: Minimum of 40 hours. When not in facility, on call.		
101-110	Aide	44	44	32
	Supervisor	8	8	8**
	Administrator	5 days/week: Minimum of 40 hours. When not in facility, on call.		
111-120	Aide	48	48	32
	Supervisor	8	8	8**
	Administrator	5 days/week: Minimum of 40 hours. When not in facility, on call.		
121-130	Aide	52	52	40
	Supervisor	8	8	8
	Administrator	5 days/week: Minimum of 40 hours. When not in facility, on call.		
131-140	Aide	56	56	40
	Supervisor	8	8	8
	Administrator	5 days/week: Minimum of 40 hours. When not in facility, on call		
141-150	Aide	60	60	40
	Supervisor	8	8	8
	Administrator	5 days/week: Minimum of 40 hours. When not in facility, on call.		
151-160	Aide	64	64	48
	Supervisor	16	16	8
	Administrator	5 days/week: Minimum of 40 hours. When not in facility, on call.		
161-170	Aide	68	68	48
	Supervisor	16	16	8
	Administrator	5 days/week: Minimum of 40 hours. When not in facility, on call.		
171-180	Aide	72	72	48
	Supervisor	16	16	8
	Administrator	5 days/week: Minimum of 40 hours. When not in facility, on call.		
181-190	Aide	76	76	56
	Supervisor	16	16	8
	Administrator	5 days/week: Minimum of 40 hours. When not in facility, on call.		
191-200	Aide	80	80	56
	Supervisor	16	16	8
	Administrator	5 days/week: Minimum of 40 hours. When not in facility, on call.		
201-210	Aide	84	84	56
	Supervisor	16	16	8
	Administrator	5 days/week: Minimum of 40 hours. When not in facility, on call.		
211-220	Aide	88	88	64
	Supervisor	16	16	16
	Administrator	5 days/week: Minimum of 40 hours. When not in facility, on call.		
221-230	Aide	92	92	64
	Supervisor	16	16	16
	Administrator	5 days/week: Minimum of 40 hours. When not in facility, on call.		
231-240	Aide	96	96	64
	Supervisor	24	24	16
	Administrator	5 days/week: Minimum of 40 hours. When not in facility, on call.		

*Supervisor may conduct up to four hours of aide duty.
** Supervisor's time on duty in the facility may be counted as required aide duty if the facility is sprinklered.

History Note: *Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 143B-165;*
Eff. September 1, 2024.

10A NCAC 13F .0609 PERSONAL CARE AIDE SUPERVISORS
(a) The personal care aide supervisor shall be responsible for the direct supervision of personal care aides, including those who administer medications, to assure that care and services are provided to residents by personal care aides in in accordance with their training, the facility's policies and procedures, the licensure rules of this Subchapter, and Chapter 131D of the general statutes. The personal care aide supervisor shall also be responsible for observing personal care aides in the performance of their duties; instructing, correcting, and consulting with aides as needed; and reviewing documentation by aides.
(b) During the first and second shifts in facilities with a census of 31 or more residents, and on third shift in facilities with a census of 91 or more residents, the facility shall have supervisors on-duty during each shift as follows:

(1) One supervisor on duty in the facility for less than 64 hours of aide duty per shift.
(2) Two supervisors for 64 to less than 96 hours of aide duty per shift.
(3) Three supervisors for 96 to less than 128 hours of aide duty per shift.

(c) Supervisors shall not provide hours of aide duty while servicing as a supervisor except as follows:

(1) On third shift, in facilities with a census of 31 to 120 residents and a sprinkler fire suppression system.
(2) On first and second shifts, up to four hours, in facilities with a census of 31 to 70 residents.
(3) On first and second shifts, in facilities with a census of 71 or more residents in which some personal care duties are performed, but the time involved in performing any personal care cannot be counted as required aide hours.

(d) On third shift, in facilities with a census of 31 to 60 residents, the supervisor shall be in the facility or within 500 feet and immediately available, as defined in Rule .0608 of this Section.
(e) On third shift, in facilities with a census of 61 to 90 residents, the supervisor shall be on duty in the facility for at least four hours and within 500 feet and immediately available, as defined in Rule .0608 of this Section, for the remaining four hours.
(f) The supervisor on duty shall not serve simultaneously as the administrator but may serve simultaneously as the manager in the absence of the administrator.

History Note: *Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 143B-165;*
Eff. September 1, 2024.

SECTION .0700 - ADMISSION AND DISCHARGE

10A NCAC 13F .0701 ADMISSION OF RESIDENTS
(a) Any adult (18 years of age or over) who, because of a temporary or chronic physical condition or mental disability, needs a substitute home may be admitted to an adult care home when, in the opinion of the resident, physician, family or social worker, and the administrator the services and accommodations of the home will meet his particular needs.
(b) People shall not be admitted:

(1) for treatment of mental illness, or alcohol or drug abuse;
(2) for maternity care;
(3) for professional nursing care under continuous medical supervision;
(4) for lodging, when the personal assistance and supervision offered for the aged and disabled are not needed; or
(5) who pose a direct threat to the health or safety of others.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .0702 DISCHARGE OF RESIDENTS (EFFECTIVE UNTIL MARCH 31, 2024)

(a) The discharge of a resident initiated by the facility shall be according to conditions and procedures specified in Paragraphs (a) through (g) of this Rule. The discharge of a resident initiated by the facility involves the termination of residency by the facility resulting in the resident's move to another location and the facility not holding the bed for the resident based on the facility's bed hold policy.

(b) The discharge of a resident shall be based on one of the following reasons:

- (1) the discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility as documented by the resident's physician, physician assistant or nurse practitioner;
- (2) the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility as documented by the resident's physician, physician assistant or nurse practitioner;
- (3) the safety of other individuals in the facility is endangered;
- (4) the health of other individuals in the facility is endangered as documented by a physician, physician assistant or nurse practitioner;
- (5) failure to pay the costs of services and accommodations by the payment due date according to the resident contract after receiving written notice of warning of discharge for failure to pay; or
- (6) the discharge is mandated under G.S. 131D-2(a1).

(c) The notices of discharge and appeal rights as required in Paragraph (e) of this Rule shall be made by the facility at least 30 days before the resident is discharged except that notices may be made as soon as practicable when:

- (1) the resident's health or safety is endangered and the resident's urgent medical needs cannot be met in the facility under Subparagraph (b)(1) of this Rule; or
- (2) reasons under Subparagraphs (b)(2), (b)(3), and (b)(4) of this Rule exist.

(d) The reason for discharge shall be documented in the resident's record. Documentation shall include one or more of the following as applicable to the reasons under Paragraph (b) of this Rule:

- (1) documentation by physician, physician assistant or nurse practitioner as required in Paragraph (b) of this Rule;
- (2) the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility's action taken to address the problem prior to pursuing discharge of the resident;
- (3) written notices of warning of discharge for failure to pay the costs of services and accommodations; or
- (4) the specific health need or condition of the resident that the facility determined could not be met in the facility pursuant to G.S. 131D-2(a1)(4) and as disclosed in the resident contract signed upon the resident's admission to the facility.

(e) The facility shall assure the following requirements for written notice are met before discharging a resident:

- (1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from the Division of Medical Assistance, 2505 Mail Service Center, Raleigh, NC 27699-2505.
- (2) A copy of the Adult Care Home Notice of Discharge with a copy of the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative on the same day the Adult Care Home Notice of Discharge is dated.
- (3) Failure to use and simultaneously provide the specific forms according to Subparagraphs (e)(1) and (e)(2) of this Rule shall invalidate the discharge. Failure to use the latest version of these forms shall not invalidate the discharge unless the facility has been previously notified of a change in the forms and been provided a copy of the latest forms by the Department of Health and Human Services.
- (4) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record.

(f) The facility shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by:

- (1) notifying staff in the county department of social services responsible for placement services;
- (2) explaining to the resident and responsible person or legal representative why the discharge is necessary;

(3) informing the resident and responsible person or legal representative about an appropriate discharge destination; and

(4) offering the following material to the caregiver with whom the resident is to be placed and providing this material as requested prior to or upon discharge of the resident:
- (A) a copy of the resident's most current FL-2;
- (B) a copy of the resident's most current assessment and care plan;
- (C) a copy of the resident's current physician orders;
- (D) a list of the resident's current medications;
- (E) the resident's current medications;
- (F) a record of the resident's vaccinations and TB screening;

(5) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (e) of this Rule:
- (A) the regional long term care ombudsman; and
- (B) the protection and advocacy agency established under federal law for persons with disabilities.

(g) If an appeal hearing is requested:

(1) the facility shall provide to the resident or legal representative or the resident and the responsible person, and the Hearing Unit copies of all documents and records that the facility intends to use at the hearing at least five working days prior to the scheduled hearing; and

(2) the facility shall not discharge the resident before the final decision resulting from the appeal has been rendered, except in those cases of discharge specified in Paragraph (c) of this Rule.

(h) If a discharge is initiated by the resident or responsible person, the administrator may require up to a 14-day written notice from the resident or responsible person which means the resident or responsible person may be charged for the days of the required notice if notice is not given or if notice is given and the resident leaves before the end of the required notice period.. Exceptions to the required notice are cases in which a delay in discharge or transfer would jeopardize the health or safety of the resident or others in the facility. The facility's requirement for a notice from the resident or responsible person shall be established in the resident contract or the house rules provided to the resident or responsible person upon admission.

(i) The discharge requirements in this Rule do not apply when a resident is transferred to an acute inpatient facility for mental or physical health evaluation or treatment and the adult care facility's bed hold policy applies based on the expected return of the resident. If the facility decides to discharge a resident who has been transferred to an acute inpatient facility and there has been no physician-documented level of care change for the resident, the discharge requirements in this Rule apply.

History Note: *Authority G.S. 131D-2.1; 131D-2.16; 131D-4.5; 131D-4.5; 131D-21; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. July 1, 2004.

10A NCAC 13F .0702 DISCHARGE OF RESIDENTS (EFFECTIVE APRIL 1, 2024)

(a) The discharge of a resident initiated by the facility shall be according to conditions and procedures specified in Paragraphs (a) through (h) of this Rule. The discharge of a resident initiated by the facility involves the termination of residency by the facility resulting in the resident's move to another location and the facility not holding the bed for the resident based on the facility's bed hold policy.

(b) The discharge of a resident initiated by the facility at the direction of the administrator or their designee shall be based on one of the following reasons:

(1) the discharge is necessary to protect the welfare of the resident and the facility cannot meet the needs of the resident, as documented by the resident's physician, physician assistant, or nurse practitioner in the resident's record;

(2) the health of the resident has improved sufficiently so that the resident is no longer in need of the services provided by the facility, as documented by the resident's physician, physician assistant, or nurse practitioner in the resident's record;

(3) the safety of the resident or other individuals in the facility is endangered as determined by the facility at the direction of the administrator or their designee in consultation with the resident's physician, physician assistant, or nurse practitioner;

(4) the health of the resident or other individuals in the facility is endangered as documented by a physician, physician assistant, or nurse practitioner in the resident's record; or

(5) the resident has failed to pay the costs of services and accommodations by the payment due date according to the resident's contract after receiving written notice of warning of discharge for failure to pay.

(c) The facility administrator or their designee shall assure the following requirements for written notice are met before discharging a resident:

(1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be completed and hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from the Division of Health Benefits, on the internet website https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms. The Adult Care Home Notice of Discharge shall include the following:
(A) the date of notice;
(B) the date of transfer or discharge;
(C) the reason for the notice;
(D) the name of responsible person or contact person notified;
(E) the planned discharge location;
(F) the appeal rights;
(G) the contact information for the long-term care ombudsman; and
(H) the signature and date of the administrator.

(2) A copy of the completed Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative and the individual identified upon admission to receive a discharge notice on behalf of the resident on the same day the Adult Care Home Notice of Discharge is dated. For the purposes of this Rule "responsible person" means a person chosen by the resident to act on their behalf to support the resident in decision-making; access to medical, social, or other personal information of the resident; manage financial matters; or receive notifications. The Adult Care Home Hearing Request Form shall include the following:
(A) the name of the resident;
(B) the name of the facility;
(C) the date of transfer or discharge;
(D) the date of scheduled transfer or discharge;
(E) the selection of how the hearing is to be conducted;
(F) the name of the person requesting the hearing; and
(G) for the person requesting the hearing, their relationship to the resident, address, telephone number, their signature, and date of the request.

(3) Provide the following material in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to the resident and the resident's legal representative and the individual identified upon admission to receive a copy the discharge notice on behalf of the resident:
(A) a copy of the resident's most current FL-2 form required in Rule .0703 of this Subchapter;
(B) a copy of the resident's current physician's orders, including medication order;

(4) Failure to use and simultaneously provide the specific forms according to Subparagraphs (c)(1) and (c)(2) of this Rule shall invalidate the discharge.

(5) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility administrator or their designee prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record.

(d) The notices of discharge and appeal rights as required in Paragraph (c) of this Rule shall be made by the facility administrator or their designee, at least 30 days before the resident is discharged except that notices may be made as soon as practicable when:

(1) the discharge is necessary to protect the welfare of the resident and the facility cannot meet the needs of the resident under Subparagraph (b)(1) of this Rule; or

(2) reasons under Subparagraphs (b)(3) and (b)(4) of this Rule exist.

(e) The following shall be documented in the resident record and shall be made available upon request to potential discharge locations pursuant to the HIPAA Standards for Privacy of Individually Identifiable Health Information which is hereby incorporated by reference, including any amendments and subsequent editions, and can be found at no cost at https://www.federalregister.gov/documents/2002/08/14/02-20554/standards-for-privacy-of-individually-identifiable-health-information:

(1) The reason for discharge to include one or more of the following as applicable to the reasons under Paragraph (b) of this Rule:
(A) documentation by physician, physician assistant or nurse practitioner as required in Paragraph (b) of this Rule;
(B) the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility's action taken to address the problem prior to pursuing discharge of the resident;
(C) written notices of warning of discharge for failure to pay the costs of services and accommodations; or
(D) the specific health need or condition of the resident that the facility determined could not be met in the facility pursuant to G.S. 131D-2.2(a)(4) and as disclosed in the resident contract signed upon the resident's admission to the facility; and

(2) any known involvement of law enforcement with the resident due to threatening behavior or violence toward self or others.

(f) The facility administrator or their designee shall document contacts with possible discharge locations and responses and make available this documentation, upon request, to the resident, legal representative, the individual identified upon admission to receive a discharge notice on behalf of the resident and the adult care home resident discharge team if convened. For the purposes of this Rule, "the individual identified upon admission to receive a discharge notice on behalf of the resident" may be the same person as the resident's legal representative or responsible person as identified in the resident's record.

(g) The facility administrator or their designee shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by:

(1) explaining to the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident why the discharge is necessary;

(2) informing the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident about an appropriate discharge destination that is capable of meeting the needs of the resident; and
(A) If at the time of the discharge notice the discharge destination is unknown or is not capable of meeting the needs of the resident, the facility administrator or their designee shall contact the local adult care home resident discharge team as defined in G.S. 131D-4.8(e) to assist with placement; and
(B) The facility, at the direction of the administrator or their designee, shall inform the resident, the resident's legal representative, the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident, and the responsible person of their right to request the Regional Long-Term Care Ombudsman to serve as a member of the adult care home resident discharge team; and

(3) offering the following material to the resident, the resident's legal representative, or the facility where the resident is to be placed and providing this material as requested prior to or upon discharge of the resident:
(A) a copy of the resident's most current FL-2 form required in Rule .0703 of this Subchapter;
(B) a copy of the resident's most current assessment and care plan;
(C) a list of referrals to licensed health professionals, including mental health;
(D) a copy of the resident's current physician orders;
(E) a list of the resident's current medications;
(F) the resident's current medications; and
(G) a record of the resident's vaccinations and TB screening;

(4) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (c) of this Rule:
(A) the regional long-term care ombudsman; and

(B) Disability Rights North Carolina, the protection and advocacy agency established under federal law for persons with disabilities;

(5) providing the resident, responsible person, or legal representative, and the individual identified upon admission who received a copy of the discharge notice on behalf of the resident with the discharge location as determined by the adult care home resident discharge team, if convened, at or before the discharge hearing, if the location is known to the facility.

(h) If an appeal hearing is requested:

(1) the facility administrator or their designee shall provide to the resident or legal representative or the resident and the responsible person, the Hearing Unit copies of all documents and records that the facility intends to use at the hearing at least five working days prior to the scheduled hearing; and

(2) the facility administrator or their designee shall not discharge the resident before the final decision resulting from the appeal has been rendered, except in those cases of discharge specified in Paragraph (d) of this Rule.

(i) If a discharge is initiated by the resident, the resident's legal representative, or responsible person, the administrator may require up to a 14-day written notice from the resident, the resident's legal representative, or responsible person which means the resident may be charged for the days of the required notice if notice is not given or if notice is given and the resident leaves before the end of the required notice period. Exceptions to the required notice are cases in which a delay in discharge or transfer would jeopardize the health or safety of the resident or others in the facility. The facility's requirement for a notice from the resident, the resident's legal representative, or responsible person shall be established in the resident contract provided to the resident or responsible person upon admission.

(j) The discharge requirements in this Rule do not apply when a resident is transferred to an acute inpatient facility for mental or physical health evaluation or treatment and the adult care facility's bed hold policy applies based on the expected return of the resident. If the facility administrator or their designee decides to discharge a resident who has been transferred to an acute inpatient facility and there has been no physician-documented level of care change for the resident, the discharge requirements in this Rule apply.

History Note: *Authority G.S. 131D-2.1; 131D-2.16; 131D-4.5; 131D-4.8; 131D-21; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. July 1, 2004;
Readopted Eff. April 1, 2024.

10A NCAC 13F .0703 TUBERCULOSIS TEST, MEDICAL EXAMINATION AND IMMUNIZATIONS

(a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions.

(b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the facility and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident.

(c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission.

(d) In the case of an unplanned, emergency admission, the medical examination of the resident shall be conducted within 72 hours after admission. Prior to an emergency admission, the facility shall obtain current medication and treatment orders from a licensed physician or physician extender.

(e) The result of the medical examination required in Paragraph (b) of this Rule shall be documented on the North Carolina Medicaid Adult Care Home FL-2 form which is available at no cost on the Department's Medicaid website at https://medicaid.ncdhhs.gov/media/6549/open. The Adult Care Home FL-2 shall be signed and dated by the physician or physician extender completing the medical examination. The medical examination shall include the following:

(1) resident's identification information, including the resident's name, date of birth, sex, admission date, county and Medicaid number, current facility and address, physician's name and address, a relative's name and address, current level of care, and recommended level of care;

(2) resident's admitting diagnoses, including primary and secondary diagnoses and dates of onset;
(3) resident's current medical information, including orientation, behaviors, personal care assistance needs, frequency of physician visits, ambulatory status, functional limitations, information related to activities and social needs, neurological status, bowel and bladder functioning status, manner of communication of needs, skin condition, respiratory status, and nutritional status including orders for therapeutic diets;
(4) special care factors, including physician orders for blood pressure, diabetic urine testing, physical therapy, range of motion exercises, a bowel and bladder program, a restorative feeding program, speech therapy, and restraints;
(5) resident's medications, including the name, strength, dosage, frequency and route of administration of each medication;
(6) results of x-rays or laboratory tests determined by the physician or physician extender to be necessary information related to the resident's care needs; and
(7) additional information as determined by the physician or physician extender to be necessary for the care of the resident.

(f) If the information on the Adult Care Home FL-2 is not clear or is insufficient, or information provided to the facility related to the resident's condition or medications after the completion of the medical examination conflicts with the information provided on the Adult Care Home FL-2, the facility shall contact the physician or physician extender for clarification in order to determine if the facility can meet the individual's needs.

(g) The results of the medical examination shall be maintained in the resident's record in accordance with Rule .1201 of this Subchapter. Discharge medication orders shall be clarified in accordance with Rule .1002(a) of this Subchapter.

(h) Upon a resident's return to the facility from a hospitalization, the facility shall obtain and review the hospital discharge summary or discharge instructions, including any discharge medication orders. If the facility identifies discrepancies between the discharge orders and current orders at the facility, the facility shall clarify the discrepancies with the resident's physician or physician extender.

(i) Each resident shall be immunized against pneumococcal disease and annually against influenza virus according to G.S. 131D-9, except as otherwise indicated in law.

(j) The facility shall make arrangements for a resident to be evaluated by a licensed mental health professional, licensed physician or licensed physician extender for follow-up psychiatric care within 30 days of admission or re-admission to the facility when the resident:
(1) has been an inpatient of a psychiatric facility within 12 months prior to admission to the facility and does not have a current plan for follow-up psychiatric care; or
(2) has been hospitalized due to threatening or violent behavior, suicidal ideation or self-harm, or other psychiatric symptoms that required hospitalization within 12 months prior to admission to the facility and does not have a current plan for follow-up psychiatric care.

History Note: Authority G.S. 131D-2.16; 143B-165;
Temporary Adoption Eff. September 1, 2003;
Eff. June 1, 2004;
Readopted Eff. June 1, 2024.

10A NCAC 13F .0704 RESIDENT CONTRACT, INFORMATION ON FACILITY, AND RESIDENT REGISTER

(a) An adult care home administrator or their management designee shall furnish and review with the resident or the resident's authorized representative as defined in Rule .1103 of this Subchapter information on the facility upon admission and when changes are made to that information. The facility shall involve the resident in the review of the resident contract and information on the facility unless the resident is cognitively unable to participate in the discussion. A statement indicating that this information has been received upon admission or amendment as required by this Rule shall be signed and dated by each person to whom it is given and retained in the resident's record in the facility. The information shall consist of the following:
(1) the resident contract to which the following applies:
(A) the contract shall specify charges for resident services and accommodations, including the cost of different levels of service, description of levels of care and services, and any other charges or fees;

(B) the contract shall disclose any health needs or conditions that the facility has determined it cannot meet;

(C) the contract shall be signed and dated by the administrator or management designee and the resident or the resident's authorized representative, a copy given to the resident or the resident's authorized representative and a copy kept in the resident's record;

(D) the resident or the resident's authorized representative shall be given a written 30-day notice prior to any change in charges for resident services and accommodations, including the cost of different levels of service, description of level of care and services, and any other charges or fees, and be provided an amended contract or an amendment to the contract for review and confirmation of receipt;

(E) gratuities in addition to the established rates shall not be accepted; and

(F) the maximum monthly adult care home rate that may be charged to Special Assistance recipients as established by the North Carolina Social Services Commission and the North Carolina General Assembly.

(2) a written copy of all house rules, including facility policies on smoking, alcohol consumption, visitation, refunds and the requirements for discharge of residents consistent with the rules of this Subchapter, and amendments disclosing any changes in the house rules. The house rules shall be in compliance with G.S. 131D-21;

(3) a copy of the Declaration of Residents' Rights as found in G.S. 131D-21;

(4) a copy of the facility's grievance procedures that shall indicate how the resident is to present complaints and make suggestions as to the facility's policies and services on behalf of himself or herself or others; and

(5) a statement as to whether the facility has signed Form DSS-1464, Statement of Assurance of Compliance with Title VI of the Civil Rights Act of 1964 for Other Agencies, Institutions, Organizations or Facilities, and which shall also indicate that, if the facility does not choose to comply or is non-compliant, the residents of the facility would not be able to receive State-County Special Assistance for Adults and the facility would not receive supportive services from the county department of social services.

(b) The administrator or their management designee and the resident or the resident's representative shall complete and sign the Resident Register initial assessment within 72 hours of the resident's admission to the facility in accordance with G.S. 131D-2.15. The facility shall involve the resident in the completion of the Resident Register unless the resident is cognitively unable to participate. The Resident Register shall consist of the following:

(1) resident's identification information including the resident's name, date of birth, sex, admission date, medical insurance, family and emergency contacts, advanced directives, and physician's name and address;

(2) resident's current care needs including activities of daily living and services, use of assistive aids, orientation status;

(3) resident's preferences including personal habits, food preferences and allergies, community involvement, and activity interests;

(4) resident's consent and request for assistance including the release of information, personal funds management, personal lockable space, discharge information, and assistance with personal mail;

(5) name of the individual identified by the resident who is to receive a copy of the notice of discharge per G.S. 131D-4.8; and

(6) resident's consent including a signature confirming the review and receipt of information contained in the form.

The Resident Register is available on the internet website, https://info.ncdhhs.gov/dhsr/acls/pdf/resregister.pdf at no charge. The facility may use a resident information form other than the Resident Register as long as it contains the same information as the Resident Register. Information on the Resident Register shall be kept updated and maintained in the resident's record.

History Note: *Authority 131D-2.15; 131D-2.16; 143B-165;*
Temporary Adoption Eff. July 1, 2004;
Eff. July 1, 2005;
Amended Eff. April 1, 2022;
Readopted Eff. June 1, 2024.

SECTION .0800 - RESIDENT ASSESSMENT AND CARE PLAN

10A NCAC 13F .0801 RESIDENT ASSESSMENT

(a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter.

(b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living. The assessment instrument established by the Department shall include the following:

(1) resident identification and demographic information;
(2) current diagnoses;
(3) current medications;
(4) the resident's ability to self-administer medications;
(5) the resident's ability to perform activities of daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating;
(6) mental health history;
(7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background;
(8) mood and behaviors;
(9) nutritional status, including specialized diet or dietary needs;
(10) skin integrity;
(11) memory, orientation and cognition;
(12) vision and hearing;
(13) speech and communication;
(14) assistive devices needed; and
(15) a list of and contact information for health care providers or services used by the resident.

The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms/dma-3050r-adult-care-home-personal-care-physician/@@display-file/form_file/dma-3050R.pdf at no cost.

(c) When a facility identifies a change in a resident's baseline condition based upon the factors listed in Parts (1)(A) through (M) of this Paragraph, the facility shall monitor the resident's condition for no more than 10 days to determine if a significant change in the resident's condition has occurred. The facility shall conduct an assessment of a resident within three days after the facility identifies that a significant change in the resident's baseline condition has occurred. The facility shall use the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows:

(1) Significant change is one or more of the following:
  (A) deterioration in two or more activities of daily living including bathing, dressing, personal hygiene, toileting, or eating;
  (B) change in ability to walk or transfer, including falls if the resident experiences repeated falls, meaning more than one, on the same day, or multiple falls that occur over several days to weeks, new onset of falls not attributed to an identifiable cause, a fall with consequent change in neurological status, or physical injury;
  (C) pain worsening in severity, intensity, or duration, occurring in a new location, or new onset of pain associated with trauma;
  (D) change in the pattern of usual behavior, new onset of resistance to care, abrupt onset or progression of agitation or combative behavior, deterioration in affect or mood, or violent or destructive behaviors directed at self or others;
  (E) no response by the resident to the intervention for an identified problem;
  (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period;
  (G) when a resident has been enrolled in hospice;

(H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or any pressure ulcer determined to be greater than Stage II;
(I) a new diagnosis of a condition which affects the resident's physical, mental, or psychosocial well-being;
(J) improved behavior, mood or functional health status to the extent that the established plan of care no longer meets the resident's needs;
(K) new onset of impaired decision-making;
(L) continence to incontinence or indwelling catheter; or
(M) the resident's condition indicates there may be a need to use a restraint in accordance with Rule .1501 of this Subchapter and there is no current restraint order for the resident.

(2) Significant change does not include the following:
(A) changes that resolve with or without intervention;
(B) an acute illness or episodic event. For the purposes of this Rule "acute illness" means symptoms or a condition that develops quickly and is not a part of the resident's baseline physical health or mental health status;
(C) an established, predictable cyclical pattern; or
(D) steady improvement under the current course of care.

(d) If a resident experiences a significant change as defined in Paragraph (c) of this Rule, the facility shall refer the resident to the resident's physician or other licensed health professional no longer than three days from the date of the significant change assessment, and document the referral in the resident's record. Referral shall be made immediately when facility staff determines that a significant change as defined in Parts (c)(1)(A)-(M) poses an immediate risk to the health and safety of the resident, other residents, or staff of the facility.
(e) The assessments required in Paragraphs (a) and (c) of this Rule shall be completed and signed by the person designated by the administrator to perform resident assessments.

History Note: Authority G.S. 131D-2.15; 131D-2.16; 131D-4.4; 131D-4.5; 143B-165;
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. September 1, 2003; July 1, 2003;
Amended Eff. July 1, 2005; June 1, 2004;
Readopted Eff. June 1, 2025.

10A NCAC 13F .0802 RESIDENT CARE PLAN

(a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan.
(b) The resident shall be offered the opportunity to participate in the development of his or her care plan. If the resident is unable to participate in the development of the care plan due to cognitive impairment, the responsible person as defined in Rule .0102 of this Subchapter shall be offered the opportunity to participate in the development of the care plan.
(c) The care plan shall include the following:
(1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section;
(2) frequency of the services or tasks to be performed;
(3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section;
(4) licensed health professional tasks required according to Rule .0903 of this Subchapter;
(5) a dated signature of the assessor upon completion; and
(6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan

Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid.

(d) If the resident received home health or hospice services, the facility shall communicate with the home health or hospice agency to coordinate care and services to ensure the resident's needs are met.

(e) The facility shall assure that the care plan for each resident who is under the care of a provider of mental health, developmental disabilities or substance use services includes instructions regarding how to contact that provider, including emergency and after-hours contacts. Whenever significant behavioral changes described in Rule .0801(c)(1)(D) of this Section are identified, the facility shall refer the resident to a provider of mental health, developmental disabilities or substance use services in accordance with Rule .0801(d) of this Section.

(f) The care plan shall be revised as needed based on the results of a significant change assessment completed in accordance with Rule .0801 of this Section.

History Note: Authority G.S. 131D-2.15; 131D-2.16; 131D-4.3; 131D-4.4; 131D-4.5; 143B-165;
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. September 1, 2003; July 1, 2003;
Amended Eff. July 1, 2005; June 1, 2004;
Readopted Eff. June 1, 2025.

SECTION .0900 – RESIDENT CARE AND SERVICES

10A NCAC 13F .0901 PERSONAL CARE AND SUPERVISION

(a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.

(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.

(c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.

History Note: Authority G.S. 131D-2.16; 131D-4.3; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 2004; April 1, 1984;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .0902 HEALTH CARE

(a) An adult care home shall provide care and services in accordance with the resident's care plan.

(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.

(c) The facility shall assure documentation of the following in the resident's record:

(1) facility contacts with the resident's physician, physician service, other licensed health professional, including mental health professional, when illnesses or accidents occur and any other facility contacts with a physician or licensed health professional regarding resident care;

(2) all visits of the resident to or from the resident's physician, physician service or other licensed health professional, including mental health professional, of which the facility is aware.

(3) written procedures, treatments or orders from a physician or other licensed health professional; and

(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.

(d) The following shall apply to the resident's physician or physician service:

(1) The resident or the resident's responsible person shall be allowed to choose a physician or physician service to attend the resident.

(2) When the resident cannot remain under the care of the chosen physician or physician service, the facility shall assure that arrangements are made with the resident or responsible person for choosing and securing another physician or physician service within 45 days or prior to the signing of the care plan as required in Rule .0802 of this Subchapter.

History Note: Authority G.S. 131D-2.16; 131D-4.3; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. September 1, 2003; July 1, 2003;
Amended Eff. July 1, 2005; June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .0903 LICENSED HEALTH PROFESSIONAL SUPPORT

(a) An adult care home shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks:

(1) applying and removing ace bandages, ted hose, binders, and braces and splints;
(2) feeding techniques for residents with swallowing problems;
(3) bowel or bladder training programs to regain continence;
(4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches;
(5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter;
(6) chest physiotherapy or postural drainage;
(7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents;
(8) collecting and testing of fingerstick blood samples;
(9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage);
(10) care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater;
(11) inhalation medication by machine;
(12) forcing and restricting fluids;
(13) maintaining accurate intake and output data;
(14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established);
(15) medication administration through injection;
Note: Unlicensed staff may only administer subcutaneous injections, excluding anticoagulants such as heparin.
(16) oxygen administration and monitoring;
(17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints;
(18) oral suctioning;
(19) care of well-established tracheostomy, not to include indo-tracheal suctioning;
(20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph(a)(14) of this Rule);
(21) the monitoring of continuous positive air pressure devices (CPAP and BIPAP);
(22) application of prescribed heat therapy;
(23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity;
(24) ambulation using assistive devices that requires physical assistance;
(25) range of motion exercises;
(26) any other prescribed physical or occupational therapy;
(27) transferring semi-ambulatory or non-ambulatory residents; or
(28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36.

(b) The appropriate licensed health professional, as required in Paragraph (a) of this Rule, is:

(1) a registered nurse licensed under G.S. 90, Article 9, for tasks listed in Subparagraphs (a)(1) through (28) of this Rule;

(2) an occupational therapist licensed under G.S. 90, Article 18D or physical therapist licensed under G.S. 90-270.90, Article 18E, for tasks listed in Subparagraphs (a)(17) and (22) through (27) of this Rule;

(3) a respiratory care practitioner licensed under G.S. 90, Article 38, for tasks listed in Subparagraphs (a)(6), (11), (16), (18), (19) and (21) of this Rule; or

(4) a registered nurse licensed under G.S. 90, Article 9, for tasks that can be performed by a nurse aide II according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36;

(c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following:

(1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;

(2) evaluating the resident's progress to care being provided;

(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and

(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

(d) The facility shall assure action is taken in response to the licensed health professional review and documented, and that the physician or appropriate health professional is informed of the recommendations when necessary.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. September 1, 2003; July 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;
Amended Eff. July 1, 2021.

10A NCAC 13F .0904 NUTRITION AND FOOD SERVICE

(a) Food Procurement and Safety in Adult Care Homes:

(1) Facilities with a licensed capacity of 7 to 12 residents shall ensure food services comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food and beverage under sanitary conditions.

(2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions.

(3) Only meat processed at a USDA-approved processing plant shall be served.

(4) There shall be a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus established in Paragraph (c) of this Rule for both regular and therapeutic diets. For the purpose of this Rule "perishable food" is food that is likely to spoil or decay if not kept refrigerated at 40 degrees Fahrenheit or below, or frozen at zero degrees Fahrenheit or below and "non-perishable food" is food that can be stored at room temperature and is not likely to spoil or decay within seven days.

(b) Food Preparation and Service in Adult Care Homes:

(1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers.

(2) Hot foods shall be served hot and cold foods shall be served cold as set forth in Rule 15A NCAC 18A .1620(a) for facilities with a licensed capacity of 7 to 12 residents and as set forth in Rule 15A NCAC 18A .1323 Food Protection in Activity Kitchens, Rehabilitation Kitchens, and Nourishment Stations for facilities with a licensed capacity of 13 or more residents, which are hereby incorporated by reference, including subsequent amendments.

(3) If residents require feeding assistance, food shall be maintained at serving temperature until assistance is provided.

(c) Menus in Adult Care Homes:

(1) Menus shall be prepared at least one week in advance with serving quantities specified and in accordance with the daily food requirements in Paragraph (d) of this Rule.

(2) Menus shall be maintained in the kitchen and identified as to the current menu day for guidance of food service staff.

(3) Any substitutions made in the menu shall be of equal nutritional value, in order to maintain the daily dietary requirements in Subparagraph (d)(3) of this Rule, appropriate for therapeutic diets, and documented in records maintained in the kitchen to indicate the foods actually served to residents.

(4) Menus shall be planned to take into account the food preferences of the residents as documented on the Resident Register.

(5) Menus as served, invoices, and other receipts for food or beverage purchases shall be maintained in the facility for 30 days.

(6) Menus for all therapeutic diets shall be planned or reviewed by a licensed dietitian/nutritionist. The facility shall maintain verification of the licensed dietitian/nutritionist's approval of the therapeutic diets.

(7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff.

(d) Food Requirements in Adult Care Homes:

(1) Each resident shall be served a minimum of three nutritionally adequate meals based on the requirements in Subparagraph (d)(3) of this Rule. Meals shall be served at regular times comparable to normal meal times in the community. There shall be at least 10 hours between the breakfast and evening meals.

(2) Foods and beverages shall be offered in accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.

(3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost.

(4) Water shall be served to each resident at each meal, in addition to other beverages.

(e) Therapeutic Diets in Adult Care Homes:

(1) All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician. Where applicable, the therapeutic diet order shall be specific to calorie, gram, or consistency, such as for calorie-controlled ADA diets, low sodium diets, or thickened liquids, unless there are written orders that include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a licensed dietitian/nutritionist. For the purpose of this Rule "therapeutic diet" is a diet ordered by a physician, physician assistant, nurse practitioner, or a licensed dietician/nutritionist as delegated by the physician that is part of the treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium or potassium), or to provide mechanically altered food when indicated.

(2) Physician orders for nutritional supplements shall be in writing from the resident's physician and be brand-specific, unless the facility has defined a house supplement in its communication to the physician, and shall specify quantity and frequency.

(3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.

(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.

(f) Individual Feeding Assistance in Adult Care Homes:

(1) The facility shall provide staff for individual feeding assistance in accordance to residents' needs.

(2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.

(g) Variations from the required three meals or time intervals between meals to meet individualized needs or preferences of residents shall be documented in the resident's record. Each resident shall receive three meals in accordance with resident preferences as documented in the resident's record.

History Note: *Authority G.S. 131D-2.1(4); 131D-2.16; 131D-4.4; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Readopted Eff. March 1, 2023.

10A NCAC 13F .0905 ACTIVITIES PROGRAM

(a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community.
(b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities.
(c) The activity director shall:

(1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities, and possible cultural differences of the residents;
(2) prepare a monthly calendar of planned group activities in a format that is legible and shall be posted in a location accessible to residents by the first day of each month, and updated when there are any changes;
(3) involve community resources, such as recreational, volunteer, and religious organizations, to enhance the activities available to residents;
(4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program;
(5) encourage residents to participate in activities; and
(6) assure there are, supplies necessary for planned activities, supervision, and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities.

(d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills.
(e) Residents shall have the opportunity to participate in activities involving one to one interaction and activity by oneself that promote enjoyment, a sense of accomplishment, increased knowledge, learning of new skills, and creative expression.
(f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so.
(g) Residents shall have the opportunity to participate in volunteer service activities in the facility or in the community. Participation in volunteer activities shall not be required of residents and shall not involve any duties or responsibilities that are outlined in the job descriptions of facility staff.

History Note: *Authority G.S. 131D-2.16; 131D-4.1; 131D-4.3;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1987; April 1, 1984;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. July 1, 2004;
Temporary Amendment Eff. July 1, 2004 (This temporary amendment replaces the permanent rule approved by RRC on May 20, 2004);
Amended Eff. July 1, 2005;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;
Amended Eff. October 1, 2022.

10A NCAC 13F .0906 OTHER RESIDENT CARE AND SERVICES

(a) Transportation. The administrator shall assure the provision of transportation for the residents of adult care homes to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the resident's choice. The resident shall not be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members as well as facility vehicles.

(b) Mail.

(1) Residents shall receive their mail promptly and it shall be unopened unless there is a written, witnessed request authorizing management staff to open and read mail to the resident. This request shall be recorded on Form DSS-1865, the Resident Register or the equivalent;

(2) Outgoing mail written by a resident shall not be censored; and

(3) Residents shall be encouraged and assisted, if necessary, to correspond by mail with close relatives and friends. Residents shall have access to writing materials, stationery and postage and, upon request, the home shall provide such items at cost. It is not the home's obligation to pay for these items.

(c) Laundry.

(1) Laundry services shall be provided to residents without any additional fee; and

(2) It is not the home's obligation to pay for a resident's personal dry cleaning. The resident's plans for personal care of clothing shall be indicated on Form DSS-1865, the Resident Register.

(d) Telephone.

(1) A telephone shall be available in a location providing privacy for residents to make and receive calls.

(2) A pay station telephone is not acceptable for local calls; and

(3) It is not the home's obligation to pay for a resident's toll calls.

(e) Personal Lockable Space.

(1) Personal lockable space shall be provided for each resident to secure his personal valuables. One key shall be provided free of charge to the resident. Additional keys shall be provided to residents at cost upon request. It is not the home's obligation to pay for additional keys; and

(2) While a resident may elect not to use lockable space, it shall still be available in the home since the resident may change his mind. This space shall be accessible only to the resident and the administrator or supervisor-in-charge. The administrator or supervisor-in-charge shall determine at admission whether the resident desires lockable space, but the resident may change his mind at any time.

(f) Visiting.

(1) Visiting in the home and community at reasonable hours shall be encouraged and arranged through the mutual prior understanding of the residents and administrator;

(2) There shall be at least 10 hours each day for visitation in the home by persons from the community. If a home has established visiting hours or any restrictions on visitation, information about the hours and any restrictions shall be included in the house rules given to each resident at the time of admission and posted conspicuously in the home;

(3) A signout register shall be maintained for planned visiting and other scheduled absences which indicates the resident's departure time, expected time of return and the name and telephone number of the responsible party;

(4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home shall immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1987; April 1, 1984;
Temporary Amendment Eff. July 1, 2003;

Amended Eff. July 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .0907 RESPITE CARE

(a) For the purposes of this Subchapter, respite care is defined as supervision, personal care and services provided for persons admitted to an adult care home on a temporary basis for temporary caregiver relief, not to exceed 30 days.
(b) Respite care is not required as a condition of licensure. However, respite care is subject to the requirements of this Subchapter except for Rules .0702, .0704(b), .0801, .0802 and .1201.
(c) The number of respite care residents and adult care home residents shall not exceed the facility's licensed bed capacity.
(d) If the facility is staffing to census, the respite care residents shall be included in the daily census for determination of appropriate staffing levels according to the rules of this Subchapter.
(e) The respite care resident contract shall specify the rates for respite care services and accommodations, the date of admission to the facility and the proposed date of discharge from the facility. The contract shall be signed by the administrator or designee and the respite care resident or his responsible person and a copy given to the resident and responsible person.
(f) Upon admission of a respite care resident into the facility, the facility shall assure that the resident has a current FL-2 and been tested for tuberculosis disease according to Rule .0703 of this Subchapter and that there are current physician orders for any medications, treatments and special diets for inclusion in the respite care resident's record. The facility shall assure that the respite care resident's physician or prescribing practitioner is contacted for verification of orders if the orders are not signed and dated within seven calendar days prior to admission to the facility as a respite care resident or for clarification of orders if orders are not clear or complete.
(g) The facility shall complete an assessment which allows for the development of a short-term care plan prior to or upon admission to the facility with input from the resident or responsible person. The assessment shall address respite resident needs, including identifying information, hearing, vision, cognitive ability, functional limitations, continence, special procedures and treatments as ordered by physician, skin conditions, behavior and mood, oral and nutritional status and medication regimen. The facility may use the Resident Register or an equivalent as the assessment instrument. The care plan shall be signed and dated by the facility's administrator or designated representative and the respite care resident or responsible person.
(h) The respite care resident's record shall include a copy of the signed respite care contract; the FL-2; the assessment and care plan; documentation of a tuberculosis test according to Paragraph (f) of this Rule; documentation of any contacts (office, home or telephone) with the resident's physician or other licensed health professionals from outside the facility; physician orders; medication administration records; a statement, signed and dated by the resident or responsible person, indicating that information on the home as required in Rule .0704(a) of this Subchapter has been received; a written description of any acute changes in the resident's condition or any incidents or accidents resulting in injury to the respite care resident, and any action taken by the facility in response to the changes, incidents or accidents; and how the responsible person or his designated representative can be contacted in case of an emergency.
(i) The respite care resident's responsible person or his designated representative shall be contacted and informed of the need to remove the resident from the facility if one or more of the following conditions exists:

(1) the resident's condition is such that he is a danger to himself or poses a direct threat to the health of others as documented by a physician; or
(2) the safety of individuals in the home is threatened by the behavior of the resident as documented by the facility.

Documentation of the emergency discharge shall be on file in the facility.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Temporary Adoption Eff. November 1, 2000;
Eff. July 18, 2002;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .0908 COOPERATION WITH CASE MANAGERS

History Note: Authority G.S. 131D-2.16; 131D-4.3; 143B-165;
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Expired Eff. April 1, 2018 pursuant to G.S. 150B-21.3A.

10A NCAC 13F .0909 RESIDENT RIGHTS

An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

History Note: Authority G.S. 131D-2.16; 131D-21; 143B-165;
Temporary Adoption Eff. July 1, 2004;
Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

SECTION .1000 - MEDICATIONS

10A NCAC 13F .1001 MEDICATION ADMINISTRATION POLICIES AND PROCEDURES

In addition to the requirements in Rule .1211(a)(1) of this Subchapter, an adult care home shall ensure the following:

(1) orientation to medication policies and procedures for staff responsible for medication administration prior to their administering or supervising the administration of medications; and

(2) compliance of medication policies and procedures with requirements of this Section and all applicable state and federal regulations, including definitions in the North Carolina Pharmacy Practice Act, G.S. 90-85.3.

For the purposes of this Subchapter, medications include herbal and non-herbal supplements.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. January 1, 1977;
Amended Eff. April 22, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2005; July 1, 2000;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1002 MEDICATION ORDERS

(a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:

(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;

(2) if orders are not clear or complete; or

(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.

The facility shall ensure that this verification or clarification is documented in the resident's record.

(b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility.

(c) The medication orders shall be complete and include the following:

(1) medication name;

(2) strength of medication;

(3) dosage of medication to be administered;

(4) route of administration;

(5) specific directions of use, including frequency of administration; and
(6) if ordered on an as needed basis, a stated indication for use.

(d) Verbal orders for medications and treatments shall be:
(1) countersigned by the prescribing practitioner within 15 days from the date the order is given;
(2) signed or initialed and dated by the person receiving the order; and
(3) accepted only by a licensed professional authorized by state occupational licensure laws to accept orders or staff responsible for medication administration.

(e) Any standing orders shall be for individual residents and signed and dated by the resident's physician or prescribing practitioner.

(f) The facility shall assure that all current orders for medications or treatments, including standing orders and orders for self-administration are reviewed and signed by the resident's physician or prescribing practitioner at least every six months.

(g) In addition to the requirements as stated in Paragraph (c) of this Rule, psychotropic medications ordered "as needed" by a prescribing practitioner, shall not be administered unless the following have been provided by the practitioner or included in an individualized care plan developed with input by a registered nurse or licensed pharmacist:
(1) detailed behavior-specific written instructions, including symptoms that might require use of the medication;
(2) exact dosage;
(3) exact time frames between dosages; and
(4) the maximum dosage to be administered in a twenty-four hour period.

(h) The facility shall assure that personal care aides and their direct supervisors receive training annually about the desired and undesired effects of psychotropic medications, including alternative behavior interventions. Documentation of training attended by staff shall be maintained in the facility.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1003 MEDICATION LABELS

(a) Labeling of prescription legend medications, except for medications prepared for a resident's leave of absence in accordance with Rule .1010(d)(4) of this Section, shall be legible and include the following information:
(1) the name of the resident for whom the medication is prescribed;
(2) the most recent date of issuance;
(3) the name of the prescriber;
(4) the name and concentration of the medication, quantity dispensed, and prescription serial number;
(5) unabbreviated directions for use stated;
(6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed;
(7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date;
(8) auxiliary information as required of the medication;
(9) the name, address, and telephone number of the dispensing pharmacy; and
(10) the name or initials of the dispensing pharmacist.

(b) For medication systems in which two or more prescribed solid oral dosage forms are packaged and dispensed together, labeling shall be in accordance with Paragraph (a) of this Rule and the label or package shall also have a physical description or identification of each medication contained in the package.

(c) The facility shall assure any changes in directions of a resident's medication by the prescriber are on the container at the refilling of the medication by the pharmacist or dispensing practitioner. The facility shall have a procedure for identifying direction changes until the container is correctly labeled in accordance with Paragraph (a) of this Rule. No person other than a licensed pharmacist or dispensing practitioner shall alter a prescription label.

(d) Non-prescription medications shall have the manufacturer's label with the expiration date visible, unless the container has been labeled by a licensed pharmacist or a dispensing practitioner in accordance with Paragraph (a) of this Rule. Non-prescription medications in the original manufacturer's container shall be labeled with at least the

resident's name and the name shall not obstruct any of the information on the container. Facility staff may label or write the resident's name on the container.
(e) Medications, prescription and non-prescription, shall not be transferred from one container to another except when prepared for a resident's leave of absence or administration to a resident.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. July 1, 2005;
Amended Eff. April 1, 2015;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1004 MEDICATION ADMINISTRATION
(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.
(b) The facility shall assure that only staff meeting the requirements in Rule .0403 of this Subchapter shall administer medications, including the preparation of medications for administration.
(c) Only oral solid medications that are ordered for routine administration may be prepared in advance and must be prepared within 24 hours of the prescribed time for administration. Medications prescribed for prn (as needed) administration shall not be prepared in advance.
(d) Liquid medications, including powders or granules that require to be mixed with liquids for administration, and medications for injection shall be prepared immediately before administration to a resident.
(e) Medications shall not be crushed for administration until immediately before the medications are administered to the resident.
(f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage:
(1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container;
(2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name;
(3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and
(4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section.
(g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations.
(h) If medications are not prepared and administered by the same staff person, there shall be documentation for each dose of medication prepared for administration by the staff person who prepared the medications when or at the time the resident's medication is prepared. Procedures shall be established and implemented to identify the staff person who prepared the medication and the staff person who administered the medication.
(i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.
(j) The resident's medication administration record (MAR) shall be accurate and include the following:
(1) resident's name;
(2) name of the medication or treatment order;
(3) strength and dosage or quantity of medication administered;
(4) instructions for administering the medication or treatment;

(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

(k) The facility shall have a system in place to ensure the resident is identified prior to the administration of any medication or treatment.
(l) The facility shall assure the development and implementation of policies and procedures governing medication errors and adverse medication reactions that include documentation of the following:
(1) notification of a physician or appropriate health professional and supervisor;
(2) action taken by the facility according to orders by the physician or appropriate health professional; and
(3) charting or documentation errors, unavailability of a medication, resident refusal of medication, any adverse medication reactions and notification of the resident's physician when necessary.

(m) Medication administration supplies, such as graduated measuring devices, shall be available and used by facility staff in order for medications to be accurately and safely administered.
(n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.
(o) A resident's medication shall not be administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly and the borrowing and replacement of the medication shall be documented.
(p) Only oral, topical (including ophthalmic and otic medications), inhalants, rectal and vaginal medications, subcutaneous injections and medications administered by gastrostomy tube and nebulizers may be administered by persons who are not authorized by state occupational licensure laws to administer medication.
(q) Unlicensed staff may not administer insulin or other subcutaneous injections prior to meeting the requirements for training and competency validation as stated in Rules .0504 and .0505 of this Subchapter.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1005 SELF-ADMINISTRATION OF MEDICATIONS

(a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met:
(1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and
(2) specific instructions for administration of prescription medications are printed on the medication label.

(b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1006 MEDICATION STORAGE

(a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified by the adult care home's medication storage policy and procedures.

(b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration.
(c) The medication storage area shall be routinely cleaned, include functional lighting, ventilated to circulate fresh air, large enough to store medications in an orderly manner, and located in areas other than the bathroom, kitchen or utility room. Medication carts shall be routinely cleaned and medications shall be stored in an orderly manner.
(d) Locked storage areas for medications shall only be accessible by staff responsible for medication administration, the administrator, or the administrator-in-charge.
(e) Medications intended for topical or external use, except for ophthalmic, otic, and transdermal medications shall be stored in a designated area separate from the medications intended for oral and injectable use. Ophthalmic, otic, and transdermal medications may be stored with medications intended for oral and injectable use. Medications shall be stored apart from cleaning agents and hazardous chemicals.
(f) Medications requiring refrigeration shall be stored at 36 degrees F to 46 degrees F (2 degrees C to 8 degrees C).
(g) Medications shall not be stored in a refrigerator containing non-medications and non-medication related items, except when stored in a separate container. The container shall be locked when storing medications unless the refrigerator is locked or is located in a locked medication area.
(h) The facility may possess a stock of non-prescription medications or the following prescription legend medications for general or common use in accordance with physicians' orders:

(1) irrigation solutions in single unit quantities exceeding 49 ml. and related diagnostic agents;
(2) diagnostic agents;
(3) vaccines; and
(4) water for injection and normal saline for injection.

(i) First aid supplies shall be immediately available to staff within the facility, stored out of sight of residents and visitors, and stored separately from medications.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. July 1, 2005;
Readopted Eff. October 1, 2022.

10A NCAC 13F .1007 MEDICATION DISPOSITION

(a) Medications shall be released to or with a resident upon discharge if the resident has a physician's order to continue the medication. Prescribed medications are the property of the resident and shall not be given to, or taken by, other staff or residents according to Rule .1004(o) of this Subchapter.
(b) Medications, excluding controlled medications that are expired, discontinued, prescribed for a deceased resident or deteriorated shall be stored separately from actively used medications until disposed of.
(c) Medications, excluding controlled medications, shall be destroyed at the facility or returned to a pharmacy within 90 days of the expiration or discontinuation of medication or following the death of the resident.
(d) All medications destroyed at the facility shall be destroyed by the administrator or the administrator's designee and witnessed by a licensed pharmacist, dispensing practitioner, or designee of a licensed pharmacist or dispensing practitioner. The destruction shall be conducted so that no person can use, administer, sell or give away the medication.
(e) Records of medications destroyed or returned to the pharmacy shall include the resident's name, the name and strength of the medication, the amount destroyed or returned, the method of destruction if destroyed in the facility and the signature of the administrator or the administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner. These records shall be maintained by the facility for a minimum of one year.
(f) A dose of any medication prepared for administration and accidentally contaminated or not administered shall be destroyed at the facility according to the facility's policies and procedures.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1008 CONTROLLED SUBSTANCES

(a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances.
(b) Controlled substances may be stored together in a common location or container. If Schedule II medications are stored together in a common location, the Schedule II medications shall be under double lock.
(c) Controlled substances that are expired, discontinued, or no longer required for a resident shall be returned to the pharmacy within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The facility shall document the resident's name; the name, strength and dosage form of the controlled substance; and the amount returned. There shall also be documentation by the pharmacy of the receipt or return of the controlled substances.
(d) If the pharmacy will not accept the return of a controlled substance, the administrator or the administrator's designee shall destroy the controlled substance within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The destruction shall be witnessed by a licensed pharmacist, dispensing practitioner, or designee of a licensed pharmacist or dispensing practitioner. The destruction shall be conducted so that no person can use, administer, sell, or give away the controlled substance. Records of controlled substances destroyed shall include the resident's name; the name, strength and dosage form of the controlled substance; the amount destroyed; the method of destruction; and, the signature of the administrator or the administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner.
(e) Records of controlled substances returned to the pharmacy or destroyed by the facility shall be maintained by the facility for three years.
(f) Controlled substances that are expired, discontinued, prescribed for a deceased resident, or deteriorated shall be stored securely in a locked area separately from actively used medications until disposed of.
(g) A dose of a controlled substance accidentally contaminated or not administered shall be destroyed at the facility. The destruction shall be conducted so that no person can use, administer, sell, or give away the controlled substance. The destruction shall be documented on the medication administration record (MAR) or the controlled substance record showing the time, date, quantity, manner of destruction, and the initials or signature of the person destroying the substance.
(h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency, and Health Care Personnel Registry as required by State law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. July 1, 2005;
Readopted Eff. October 1, 2022.

10A NCAC 13F .1009 PHARMACEUTICAL CARE

(a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk.
Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following:

(1) an on-site medication review for each resident which includes the following:
   (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and
   (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and
   (C) documenting the results of the medication review in the resident's record;
(2) review of all aspects of medication administration including the observation or review of procedures for the administration of medications and inspection of medication storage areas;

(3) review of the medication system utilized by the facility, including packaging, labeling and availability of medications;

(4) review the facility's procedures and records for the disposition of medications and provide assistance, if necessary;

(5) provision of a written report of findings and any recommendations for change for Subparagraphs (a)(1) through (4) of this Rule to the facility and the physician or appropriate health professional, when necessary;

(6) conducting in-service programs as needed for facility staff on medication usage that includes the following:

    (A) potential or current medication related problems identified;

    (B) new medications;

    (C) side effects and medication interactions; and

    (D) policies and procedures.

(b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary.

(c) The facility shall maintain the findings and reports resulting from the activities in Subparagraphs (a)(1) through (6) of this Rule in the facility, including action taken by the facility.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1010 PHARMACEUTICAL SERVICES

(a) An adult care home shall allow the residents the right to choose a pharmacy provider as long as the pharmacy provides services that are in accordance with requirements of this Section, all applicable State and federal rules and regulations, and the facility's medication management policies and procedures.

(b) There shall be a current, written agreement with a licensed pharmacist or a prescribing practitioner for pharmaceutical care services in accordance with Rule .1009 of this Section. The written agreement shall include a statement of the responsibility of each party.

(c) The facility shall assure the provision of pharmaceutical services to meet the needs of the residents including procedures that assure the accurate ordering, receiving, and administering of all medications prescribed on a routine, emergency, or as needed basis.

(d) The facility shall assure the provision of medication for residents on temporary leave from the facility or involved in day activities out of the facility. The facility shall have written policies and procedures for a resident's temporary leave of absence. The policies and procedures shall facilitate safe administration by assuring that upon receipt of the medication for a leave of absence the resident or the person accompanying the resident is able to identify the medication, dosage, and administration time for each medication provided for the temporary leave of absence. The policies and procedures shall include the following provisions:

(1) The amount of resident's medications provided shall be sufficient and necessary to cover the duration of the resident's absence. For the purposes of this Rule, sufficient and necessary means the amount of medication to be administered during the leave of absence or only a current dose pack, card, or container if the current dose pack, card, or container has enough medication for the planned absence;

(2) written and verbal instructions for each medication to be released for the resident's absence shall be provided to the resident or the person accompanying the resident upon the medication's release from the facility and shall include:

    (A) the name and strength of the medication;

    (B) the directions for administration as prescribed by the resident's physician; and

    (C) any cautionary information from the original prescription package if the information is not on the container released for the leave of absence;

(3) the resident's medication shall be provided in a capped or closed container that will protect the medications from contamination and spillage; and

(4) labeling of each of the resident's individual medication containers for the leave of absence shall be legible, include at least the name of the resident and the name and strength of the medication, and be affixed to each container.

The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation of the quantities of medications released from and returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications' release from and return to the facility.
(e) The facility shall assure that accurate records of the receipt, use, and disposition of medications are maintained in the facility and available upon request for review.
(f) A facility with 12 or more beds shall have a current, written agreement with a pharmacy provider for dispensing services. The written agreement shall include a statement of the responsibility of each party.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. July 1, 2005;
Amended Eff. April 1, 2015;
Readopted Eff. October 1, 2022.

SECTION .1100 – RESIDENT'S FUNDS AND REFUNDS

10A NCAC 13F .1101 MANAGEMENT OF RESIDENTS FUNDS

(a) Residents shall manage their own funds if possible.
(b) In situations where a resident is unable to manage his funds, a legal representative or payee shall be designated in accordance with Rule .1103 of this Section.
(c) Residents shall endorse checks made out to them unless a legal representative or payee has been authorized to endorse checks.

History Note: Authority G.S. 35A-1203; 108A-37; 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1102 REFUND POLICY

An adult care home's refund policies shall be in writing and signed by the administrator. A copy shall be given to each resident or the resident's responsible person at time of admission. A copy shall also be filed in the resident's record.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1103 AUTHORIZED REPRESENTATIVE

(a) In situations where the facility determines a resident of an adult care home is unable to manage their monetary funds, the administrator shall contact the resident's responsible person or the county department of social services regarding the need for an authorized representative. For the purposes of this Section, an "authorized representative" shall mean a person who is legally authorized or designated in writing by the resident to act on his or her behalf in the management of their funds.
(b) The administrator and other staff of the home facility shall not serve as a resident's authorized representative, payee, or executor of a will except in the case of funds administered by the Social Security Administration, the Veteran's Administration or other federal government agencies. The administrator of the facility may serve as a payee when so authorized as a legally constituted authority by the respective federal agencies.
(c) The administrator shall give the resident's authorized representative or payee receipts for any monies received on behalf of the resident.

History Note: Authority G.S. 35A-1203; 108A-37; 131D-2.16; 143B-165;
Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;
Amended Eff. June 1, 2024.

10A NCAC 13F .1104 ACCOUNTING FOR RESIDENT'S PERSONAL FUNDS

(a) To document a resident's receipt of the State-County Special Assistance personal needs allowance after payment of the cost of care, a statement shall be signed by the resident or marked by the resident. If the statement is marked by the resident, there shall be one witness signature. For residents who have been adjudicated incompetent, the signature of the resident's authorized representative shall be required. Witnesses cannot include the staff handling the residents' personal funds transactions. The statement shall be maintained in the facility.
(b) No employee of a facility shall handle the personal funds for a resident, except for the facility administrator or the administrator's designee after having received prior written authorization from the resident or the resident's authorized representative. The facility administrator or their designee shall maintain an accurate account balance and accounting of all funds received, disbursements, and the balance on hand which shall be available upon request to the resident or their authorized representative during the facility's regular business office hours.
(c) The facility shall provide each resident or the resident's authorized representative a written monthly accounting of the resident's funds handled by the administrator or the administrator's designee. The facility shall maintain at the facility a record signed by the resident or their authorized representative indicating whether the resident or their authorized representative agrees that the monthly accounting is accurate. The records shall be maintained by the facility for at least one year.
(d) A resident's personal funds shall not be commingled with facility funds. The facility shall not commingle the personal funds of residents in an interest-bearing account.
(e) All or any portion of a resident's personal funds shall be available to the resident or their authorized representative upon request during the facility's established business days and hours except as provided in Rule .1105 of this Section.
(f) The resident's personal needs allowance shall be credited to the resident's account within one business day of the funds being available in the facility's resident personal funds account.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;
Amended Eff. June 1, 2024.

10A NCAC 13F .1105 REFUND OF PERSONAL FUNDS

(a) When the administrator or the administrator's designee handles a resident's personal money at the resident's or his payee's request, the balance shall be given to the resident or the resident's responsible person within 14 days of the resident's leaving the home.
(b) If a resident dies, the administrator of his estate or the Clerk of Superior Court, when no administrator for his estate has been appointed, shall be given all of his personal funds within 30 days after death.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1106 SETTLEMENT OF COST OF CARE

(a) If a resident of an adult care home, has been notified by the facility of its intent to discharge in accordance with Rule .0702 of this Subchapter, the facility shall refund the resident an amount equal to the cost of care for the remainder of the month minus the amount charged for any nights spent in the facility during the notice period. The refund shall be made within 14 days after the resident leaves the facility. For the purposes of this Rule, "cost of care" means any monies paid by the resident or the resident's legal representative in advance for room and board and services provided by the facility as agreed upon in the resident's contract.

(b) When a resident moves out of the facility without giving notice, as may be required by the facility according to Rule .0702(i) of this Subchapter, or before the facility's required notice period has elapsed, the facility shall charge the resident no more than the amount equal to the cost of care for the required notice period. If a resident receiving State-County Special Assistance moves before the facility's required notice period has elapsed, the facility may charge the resident for the required notice period. The facility shall refund the resident the remainder of any advance payment following settlement of the cost of care. The refund shall be made within 14 days from the date of notice or, if no notice is given, within 14 days after the resident leaves the facility.
(c) When there is an exception to the notice as provided in Rule .0702(i) of this Subchapter, to protect the health or safety of the resident or others in the facility, or when there is a sudden, unexpected closure of the facility that requires the resident to relocate, the facility shall only charge the resident for any nights spent in the facility. A refund shall be made to the resident by the facility within 14 days from the date of notice.
(d) When a resident gives notice of leaving the facility, as may be required by the facility according to Rule .0702(i) of this Subchapter, and leaves at the end of the notice period, the facility shall refund the resident the remainder of any advance payment within 14 days from the date of notice. If notice is not required by the facility, the refund shall be made within 14 days after the resident leaves the facility.
(e) When a resident leaves the facility and the resident or his or her responsible person has notified the facility of the intent of returning to it, the following apply:

(1) If the resident or their responsible party reserves their bed for a set number of days, the facility shall have a written agreement for the payment for the days the bed is held in accordance with Rule .0704(a)(1)(A) of this Subchapter.
(2) If, after leaving the facility, the resident decides not to return to it, the facility shall require no more than a 14-day written notice that he or she is not returning.
(3) If the facility requires a 14-day written notice, the requirement shall be a part of the written agreement and explained by the facility to the resident and his or her family or responsible person before signing.
(4) When a resident or someone acting on his or her behalf notifies the facility that he or she will not be returning to the facility, the facility shall refund the remainder of any advance payment to the resident or his or her responsible person. The refund shall include the amount equal to the cost of care for the period covered by the agreement. The refund shall be made within 14 days after notification that the resident will not be returning to the facility.
(5) The facility shall not require payment from a resident that receives State County Special Assistance for more than 30 days unless the resident is actually residing in the facility or it is anticipated that he or she will return to the facility within 30 days.
(6) Exceptions to the 14-day notice, if required by the facility, are cases where returning to the facility would jeopardize the health or safety of the resident or others in the facility as certified by the resident's physician or approved by the county department of social services, and in the case of the resident's death. In these cases, the facility shall provide a refund the rest of any advance payment calculated beginning with the day the facility is notified. The facility shall provide the refund to the authorized representative with 14 days after the resident leaves the facility or within 30 days after the resident's death.

(f) If a resident dies, the administrator of his or her estate or the Clerk of Superior Court, when no administrator for his or her estate has been appointed, shall be given a refund equal to the cost of care for the month minus any nights spent in the facility during the month. This is to be done within 30 days after the resident's death.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. July 1, 2005;
Readopted Eff. June 1, 2024.

SECTION .1200 – POLICIES, RECORDS AND REPORTS

10A NCAC 13F .1201 RESIDENT RECORDS

(a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services:

(1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable;

(2) Resident Register;
(3) receipt for the following as required in Rule .0704 of this Subchapter:
  (A) contract for services, accommodations and rates;
  (B) house rules as specified in Rule .0704(a)(2) of this Subchapter;
  (C) Declaration of Residents' Rights (G.S. 131D-21);
  (D) the home's grievance procedures; and
  (E) civil rights statement;
(4) resident assessment and care plan;
(5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter;
(6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation;
(7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and
(8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged.

When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident.

(b) A resident financial record providing an accurate accounting of the receipt and disbursement of the resident's personal funds if handled by the facility according to Rule .1101 of this Subchapter shall be maintained on each resident in an orderly manner in the facility and made available for review by representatives of the Division of Health Service Regulation and county departments of social services. When there is an approved cluster of licensed facilities, financial records may be kept in one location among the clustered facilities.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1202 DISPOSAL OF RESIDENT RECORDS

After a resident has left an adult care home or died, the resident's records shall be filed in the facility for at least one year and then stored for at least two more years.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. July 1, 2005; June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1203 REPORT OF ADMISSIONS AND DISCHARGES

History Note: Authority G.S. 131D-2; 143B-165; S.L. 2002-0160;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Repealed Eff. July 1, 2005.

10A NCAC 13F .1204 POPULATION REPORT

History Note: Authority G.S. 131D-2; 143B-153; 143B-165; S.L. 2002-160;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. July 1, 2003;
Temporary Repeal Eff. September 1, 2003;
Repealed Eff. June 1, 2004.

10A NCAC 13F .1205 HEALTH CARE PERSONNEL REGISTRY

The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 131E-256; 143B-165;
Temporary Adoption Eff. January 1, 2000;
Eff. July 1, 2000;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1206 MARKETING

An adult care home may market provided:

(1) the name used is as it appears on the license;
(2) only the services and accommodations for which the home is licensed are used; and
(3) the home is classified by licensure status.

History Note: Authority G.S. 131D-2.1; 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. July 1, 2004;
Readopted Eff. January 1, 2020.

10A NCAC 13F .1207 FACILTIES TO REPORT RESIDENT DEATHS

The facility shall report resident deaths to the Division of Health Service Regulation in accordance with G.S. 131D-34.1.

History Note: Authority G.S. 131D-2.4; 131D-2.16; 131D-34.1; 143B-165;
Temporary Adoption Eff. May 1, 2001;
Eff. July 18, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;
Amended Eff. October 1, 2022.

10A NCAC 13F .1208 DEATH REPORTING REQUIREMENTS

(a) Upon learning of a resident death as described in Paragraphs (b) and (c) of this Rule, a facility shall file a report in accordance with this Rule. A facility shall be deemed to have learned of a resident death when any facility staff obtains information that the death occurred.

(b) A written notice containing the information listed under Paragraph (d) of this Rule shall be made immediately for the following:

(1) a resident death occurring in an adult care home within seven days of the the use of a physical restraint or physical hold on the resident; or
(2) a resident death occurring within 24 hours of the resident's transfer from the adult care home to a hospital, if the death occurred within seven days of physical restraint or physical hold of the resident.

(c) A written notice containing the information under Paragraph (d) of this Rule shall be made within three days of any death resulting from violence, accident, suicide or homicide.

(d) Written notice may be submitted in person or by telefacsimile or electronic mail. If the reporting facility does not have the capacity or capability to submit a written notice immediately, the information contained in the notice

may be reported by telephone following the same time requirements under Subparagraphs (b) and (c) of this Rule until such time the written notice may be submitted. The notice shall include at least the following information:

(1) Reporting facility: Name, address, county, license number (if applicable), Medicare/Medicaid provider number (if applicable), facility administrator and telephone number, name and title of person preparing report, first person to learn of death and first staff to receive report of death, and date and time report prepared;

(2) Resident information: Name, Medicaid number (if applicable), date of birth, age, sex, race, primary admitting diagnoses, and date of most recent admission to an acute care hospital.

(3) Circumstances of death: place and address where resident died, date and time death was discovered, physical location decedent was found, cause of death (if known), whether or not decedent was restrained at the time of death or within 7 days of death and if so, a description of the type of restraint and its usage, and a description of events surrounding the death; and

(4) Other information: list of other authorities such as law enforcement or the County Department of Social Services that have been notified, have investigated or are in the process of investigating the death or events related to the death.

(e) The facility shall submit a written report, using a form pursuant to G.S. 131D-34.1(e). The facility shall provide, fully and accurately, all information sought on the form. If the facility is unable to obtain any information sought on the form, or if any such information is not yet available, the facility shall so explain on the form.

(f) In addition, the facility shall:

(1) Notify the Division of Health Service Regulation immediately whenever it has reason to believe that information provided may be erroneous, misleading, or otherwise unreliable;

(2) Submit to the Division of Health Service Regulation, immediately after it becomes available, any information required by this rule that was previously unavailable; and

(3) Provide, upon request by the Division of Health Service Regulation, other information the facility obtains regarding the death, including, but not limited to, death certificates, autopsy reports, and reports by other authorities.

(g) With regard to any resident death under circumstances described in G.S. 130A-383, a facility shall notify the appropriate law enforcement authorities so the medical examiner of the county in which the body is found may be notified. Documentation of such notification shall be maintained by the facility and be made available for review by the Division upon request.

(h) In deaths not under the jurisdiction of the medical examiner, the facility shall notify the decedent's next-of-kin, or other individual authorized according to G.S. 130A-398, that an autopsy may be requested as designated in G.S. 130A-389.

History Note: *Authority G.S. 131D-2.16; 131D-34.1;*
Temporary Adoption Eff. May 1, 2001;
Eff. July 18, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1209 DEFINITIONS APPLICABLE TO DEATH REPORTING

The following definitions shall apply throughout this Section:

(1) "Accident" means an unexpected, unnatural or irregular event contributing to a resident's death and includes, but is not limited to, medication errors, falls, fractures, choking, elopement, exposure, poisoning, drowning, fire, burns or thermal injury, electrocution, misuse of equipment, motor vehicle accidents, and natural disasters.

(2) "Immediately" means at once, at or near the present time, without delay.

(3) "Violence" means physical force exerted for the purpose of violating, damaging, abusing or injuring. or abusing another person.

History Note: *Authority G.S. 131D-2.16; 131D-34.1;*
Temporary Adoption Eff. May 1, 2001;
Eff. July 18, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1210 RECORD OF STAFF QUALIFICATIONS
An adult care home shall maintain records of staff qualifications required by the rules in Section .0400 of this Subchapter in the facility. When there is an approved cluster of licensed facilities, these records may be kept in one location among the clustered facilities.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Temporary Adoption Eff. July 1, 2004;
Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1211 WRITTEN POLICIES AND PROCEDURES
(a) An adult care home shall develop written policies and procedures that comply with applicable rules of this Subchapter, on the following:

(1) ordering, receiving, storage, discontinuation, disposition, administration, including self-administration, and monitoring the resident's reaction to medications, as developed in consultation with a licensed health professional who is authorized to dispense or administer medications;
(2) use of alternatives to physical restraints and the care of residents who are physically restrained, as developed in consultation with a registered nurse;
(3) accident, fire safety and emergency procedures;
(4) infection control;
(5) refunds;
(6) missing resident;
(7) identification and supervision of wandering residents;
(8) management of physical aggression or assault by a resident;
(9) handling of resident grievances;
(10) visitation in the facility by guests; and
(11) smoking and alcohol use.

(b) In addition to other training and orientation requirements in this Subchapter, all staff shall be trained within 30 days of hire on the policies and procedures listed as Subparagraphs (3), (4), (6), (7), (8), (9), (10) and (11) in Paragraph (a) of this Rule.
(c) Policies and procedures on which staff have been trained shall be available within the facility to staff for their reference.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1212 REPORTING OF ACCIDENTS AND INCIDENTS
(a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.
(b) Notification as required in Paragraph (a) of this Rule shall be by a copy of the death report completed according to Rule .1208 of this Subchapter or a written report that shall provide the following information:

(1) resident's name;
(2) name of staff who discovered the accident or incident;
(3) name of the person preparing the report;
(4) how, when and where the accident or incident occurred;
(5) nature of the injury;
(6) what was done for the resident, including any follow-up care;
(7) time of notification or attempts at notification of the resident's responsible person or contact person as required in Paragraph (e) of this Rule; and
(8) signature of the administrator or administrator-in-charge.

(c) The report as required in Paragraph (b) of this Rule shall be submitted to the county department of social services by mail, telefacsimile, electronic mail, or in person within 48 hours of the initial discovery or knowledge by staff of the accident or incident.
(d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident.
(e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification:

(1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and
(2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter.

(f) When a resident is at risk that death or physical harm will occur as a result of physical violence by another person, the facility shall immediately report the situation to the local law enforcement authority.
(g) In the case of physical assault by a resident or whenever there is a risk that death or physical harm will occur due to the actions or behavior of a resident, the facility shall immediately:

(1) seek the assistance of the local law enforcement authority;
(2) provide additional supervision of the threatening resident to protect others from harm;
(3) seek any needed emergency medical treatment;
(4) make a referral to the Local Management Entity for Mental Health Services or mental health provider for emergency treatment of the threatening resident; and
(5) cooperate with assessment personnel assigned to the case by the Local Management Entity for Mental Health Services or mental health provider to enable them to provide their earliest possible assessment.

(h) The facility shall immediately report any assault resulting in harm to a resident or other person in the facility to the local law enforcement authority.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1213 AVAILABILITY OF CORRECTIVE ACTION AND SURVEY REPORTS

An adult care home shall make available to residents and their families or responsible persons and to prospective residents and their families or responsible persons, upon request and in a location accessible to residents and visitors in the home the following:

(1) the most recent annual or biennial and subsequent facility survey reports issued by the Adult Care Licensure Section of the Division of Health Service Regulation;
(2) any other reports issued by the Adult Care Licensure Section of the Division of Health Service Regulation within the past 12 months; and
(3) corrective action reports issued by the county department of social services within the past 12 months.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. July 1, 2005;
Readopted Eff. January 1, 2022.

SECTION .1300 - SPECIAL CARE UNITS FOR ALZHEIMER AND RELATED DISORDERS

10A NCAC 13F .1301 DEFINITIONS APPLICABLE TO SPECIAL CARE UNITS

The following definitions shall apply throughout this Section:

(1) "Alzheimer's Disease" means a progressive, degenerative disease that attacks the brain and results in impaired memory, thinking and behavior. Characteristic symptoms of the disease include gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and loss of language skills.

(2) "Related disorders" means dementing or memory impairing conditions characterized by irreversible memory dysfunction.

(3) "Special care unit for persons with Alzheimer's Disease or related disorders" means an entire facility or any section, wing or hallway within an adult care home separated by closed doors from the rest of the home, or a program provided by an adult care home, that is designated or advertised especially for special care of residents with Alzheimer's Disease or related disorders.

(4) "Care coordinator" means a staff person in a special care unit who oversees resident care and coordinates, supervises and evaluates resident services to assure that each resident receives services appropriate to the individual's needs.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 131D-4.6; 131D-8; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1302 SPECIAL CARE UNIT DISCLOSURE

(a) Only those facilities with units that meet the requirements of this Section may advertise, market or otherwise promote themselves as providing special care units for persons with Alzheimer's Disease or related disorders.

(b) The facility shall disclose information about the special care unit according to G.S. 131D-8 and which addresses policies and procedures listed in Rule .1305 of this Section.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 131D-4.6; 131D-8; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1303 LICENSURE OF FACILITIES WITH SPECIAL CARE UNITS

A facility that advertises, markets or otherwise promotes itself as having a special care unit for residents with Alzheimer's Disease or related disorders and meets the requirements of this Section for special care units and the rules set forth in this Subchapter shall be licensed as an adult care home with a special care unit. The license shall indicate that a special care unit for residents with Alzheimer's Disease or related disorders is provided.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 131D-4.6; 131D-8; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1304 SPECIAL CARE UNIT PHYSICAL ENVIRONMENT REQUIREMENTS

In addition to meeting all applicable building codes and licensure regulations for adult care homes, the special care unit shall meet the following building requirements:

(1) For facilities licensed prior to April 1, 2025, the following shall apply:

(a) Plans for new or renovated construction or conversion of existing building areas shall be submitted to the Construction Section of the Division of Health Service Regulation for review and approval.

(b) If the special care unit is a portion of a facility, it shall be separated from the rest of the building by closed doors.

(c) Unit exit doors may be locked only if the locking devices meet the requirements outlined in the N.C. State Building Code for special locking devices.

(d) Where exit doors are not locked, a system of security monitoring shall be provided.

(e) The unit shall be located so that other residents, staff and visitors do not have to routinely pass through the unit to reach other areas of the building.

(f) At a minimum the following service and storage areas shall be provided within the special care unit: staff work area, nourishment station for the preparation and provision of snacks, lockable space for medication storage, and storage area for the residents' records.

(g) Living and dining space shall be provided within the unit at a total rate of 30 square feet per resident and may be used as an activity area.

(h) Direct access from the facility to a secured outside area shall be provided.

(i) A toilet and hand lavatory shall be provided within the unit for every five residents.

(j) A tub and shower for bathing of residents shall be provided within the unit.

(k) Use of potentially distracting mechanical noises such as loud ice machines, window air conditioners, intercoms and alarm systems shall be minimized or avoided.

(2) For facilities licensed on or after April 1, 2025, the following shall apply:

(a) A special care unit that is part of an adult care home shall meet licensure rules for adult care homes contained in Rules .0301-.0311 of this Subchapter with the following exceptions: .0305(e)(3), .0305(f)(1), .0305(f)(4), .0305(h)(3), .0305(k), and .0305(l).

(b) The unit, if part of an adult care home, shall be separated from the rest of the facility by walls and closed doors.

(c) The unit, if part of an adult care home, shall be located so that other residents, staff, and visitors will not have to pass through the unit to reach other areas of the facility.

(d) Unit exit doors shall be locked with locking devices meeting the requirements outlined in the North Carolina State Building Code for special locking arrangements.

(e) Unit exit doors shall have a sounding device that is activated when the door is opened per Rule .0305(h)(4) of this Subchapter.

(f) Operable exterior windows shall be equipped with mechanisms to limit window openings to no less than four inches and no greater than six inches to minimize the chance of elopement.

(g) There shall be direct access from the unit to a secured outside area located on the same level as the unit.

(h) Fences used to enclose the secured outside area shall be at least six feet high and shall be constructed to prevent residents' ability to climb over the fence.

(i) The following service and storage areas shall be provided within the special care unit:

(i) a staff work area;

(ii) a staff bathroom;

(iii) a nourishment station for the preparation and provision of snacks. The nourishment station shall be provided with a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four and one half inches in length. If the sink faucet depends on the building electrical service for operation, the faucet must have an emergency power source or battery backup capability. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;

(iv) lockable space for medication storage;

(v) storage area for the residents' records;

(vi) separate storage room or area shall be provided for the storage of soiled linens; and

(vii) a housekeeping closet, with mop sink or mop floor receptor.

(j) The living room and dining room/dining area may be sized per Rules .0305(b) and .0305(c) of this Subchapter or may be combined for a minimum of 30 square feet per resident. The combined space may be used as an activity area.

(k) The unit shall have a central bathing area meeting the following:

(i) a door of three feet minimum width;

(ii) a roll-in shower designed to allow the staff to assist a resident in taking a shower without the staff getting wet. The roll-in shower shall be designed and equipped for unobstructed ease of shower chair entry and use. If a bathroom with a roll-in

shower designed and equipped for unobstructed ease of shower chair entry adjoins each resident bedroom in the facility, the central bathing area is not required to have a roll-in shower;

(iii) a bathtub, a manufactured walk-in tub or a similar manufactured bathtub designed for easy transfer of residents into the tub. Bathtubs shall be accessible on three sides. Manufactured walk-in tubs or a similar manufactured bathtub shall be accessible on at least two sides. Staff shall not be required to reach over or through the tub faucets and other fixture fittings to assist the resident in the tub;

(iv) a toilet and a lavatory trimmed with valves that can be operated without hands. If the lavatory is equipped with blade handles, the blade handles shall not be less than four and one half inches in length. If the lavatory faucet depends on the building electrical service for operation, the faucet must have an emergency power source or battery backup capability. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets; and

(v) individual cubicle curtains shall enclose each toilet, bathtub, manufactured walk-in tub or similar manufactured bathtub, and shower.

(l) If each resident bedroom has direct access to a bathroom equipped with a shower meeting the requirements of Rule .0305(e)(7)(B) of this Subchapter, the shower required by this rule is not required to be provided in the unit.

(m) Fire extinguishers required by Rule .0308(a) of this Subchapter shall be secured in a manner acceptable to the local Fire Marshal to prevent access by residents.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 131D-4.6; 131D-8; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Readopted Eff. April 1, 2025.

10A NCAC 13F .1305 SPECIAL CARE UNIT POLICIES AND PROCEDURES

The facility shall assure that special care unit policies and procedures are established, implemented by staff and available for review within the facility. In addition to all applicable policies and procedures for adult care homes, there shall be policies and procedures that address the following:

(1) the philosophy of the special care unit which includes a statement of mission and objectives regarding the specific population to be served by the unit which shall address, but not be limited to, the following:

(a) safe, secure, familiar and consistent environment that promotes mobility and minimal use of physical restraints or psychotropic medications;

(b) a structured but flexible lifestyle through a well developed program of care which includes activities appropriate for each resident's abilities;

(c) individualized care plans that stress the maintenance of residents' abilities and promote the highest possible level of physical and mental functioning; and

(d) methods of behavior management which preserve dignity through design of the physical environment, physical exercise, social activity, appropriate medication administration, proper nutrition and health maintenance;

(2) the process and criteria for admission to and discharge from the unit;

(3) a description of the special care services offered in the unit;

(4) resident assessment and care planning, including opportunity for family involvement in care planning, and the implementation of the care plan, including responding to changes in the resident's condition;

(5) safety measures addressing dementia specific dangers such as wandering, ingestion, falls and aggressive behavior;

(6) staffing in the unit;

(7) staff training based on the special care needs of the residents;

(8) physical environment and design features that address the needs of the residents;

(9) activity plans based on personal preferences and needs of the residents;

(10) opportunity for involvement of families in resident care and the availability of family support programs; and

(11) additional costs and fees for the special care provided.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 131D-4.6; 131D-8; 143-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1306 ADMISSION TO THE SPECIAL CARE UNIT

In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit:

(1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served.

(2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit.

(3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 131D-4.6; 131D-8; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1307 SPECIAL CARE UNIT RESIDENT PROFILE AND CARE PLAN (EFFECTIVE UNTIL MARCH 31, 2024)

In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following:

(1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment.

(2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 131D-4.6; 131D-8; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000.

10A NCAC 13F .1307 SPECIAL CARE UNIT RESIDENT PROFILE AND CARE PLAN (EFFECTIVE APRIL 1, 2024)

In addition to the requirements in Rules .0801 and .0802 of this Subchapter, the facility shall:

(1) Within 30 days of admission to the special care unit and quarterly thereafter, develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment.

(2) Develop or revise the resident's care plan required in Rule .0802 of this Subchapter based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 131D-4.6; 143B-165;*
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Readopted Eff. April 1, 2024.

10A NCAC 13F .1308 SPECIAL CARE UNIT STAFFING

(a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.
(b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents.
(c) In units of 16 or more residents and any units that are freestanding facilities, there shall be a care coordinator as required in Paragraph (b) of this Rule in addition to the staff required in Paragraph (a) of this Rule.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 131D-4.6; 131D-8; 143B-165;*
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1309 SPECIAL CARE UNIT STAFF ORIENTATION AND TRAINING

The facility shall assure that special care unit staff receive at least the following orientation and training:

(1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement.
(2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents.
(3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule.
(4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 131D-4.6; 131D-8; 143B-165;*
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1310 OTHER APPLICABLE RULES FOR SPECIAL CARE UNITS

In addition to specific rules pertaining to special care units for residents in this Section, such units shall also meet all other applicable requirements governing the operation of adult care homes as set forth in this Subchapter.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 131D-4.6; 131D-8; 143B-165;*
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

SECTION .1400 – SPECIAL CARE UNITS FOR MENTAL HEALTH DISORDERS

10A NCAC 13F .1401 DEFINITIONS APPLICABLE TO SPECIAL CARE UNITS

10A NCAC 13F .1402 SPECIAL CARE UNIT DISCLOSURE
10A NCAC 13F .1403 LICENSURE OF FACILITIES WITH SPECIAL CARE UNITS
10A NCAC 13F .1404 SPECIAL CARE UNIT BUILDING REQUIREMENTS
10A NCAC 13F .1405 SPECIAL CARE UNIT POLICIES AND PROCEDURES
10A NCAC 13F .1406 ADMISSION TO THE SPECIAL CARE UNIT
10A NCAC 13F .1407 SPECIAL CARE UNIT RESIDENT PROFILE AND CARE PLAN
10A NCAC 13F .1408 SPECIAL CARE UNIT STAFFING
10A NCAC 13F .1409 SPECIAL CARE UNIT STAFF ORIENTATION AND TRAINING
10A NCAC 13F .1410 RESIDENTS' RIGHTS
10A NCAC 13F .1411 OTHER APPLICABLE RULES FOR SPECIAL CARE UNITS

History Note: Authority G.S. 131D-2.16; 131D-4.5; 131D-4.6; 131D-8; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Expired Eff. April 1, 2018 pursuant to G.S. 150B-21.3A.

SECTION .1501 - USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES

10A NCAC 13F .1501 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES

(a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and that restricts freedom of movement or normal access to one's body, shall be:

(1) used only in those circumstances in which the resident has medical symptoms for which the resident's physician or physician extender has determined warrant the use of restraints and not for discipline or convenience purposes;
(2) used only with a written order from a physician or physician extender except in emergencies where the health or safety of the resident is threatened, according to Paragraph (d) of this Rule;
(3) the least restrictive restraint that would provide a safe environment for the resident and prevent physical injury;
(4) used only after alternatives that would provide a safe environment for the resident to prevent physical injury and prevent a potential decline in the resident's functioning have been tried and documented by the administrator or their designee in the resident's record as being unsuccessful;
(5) used only after an assessment and care planning process has been completed, except in emergencies where the health or safety of the resident is threatened, according to Paragraph (d) of this Rule;
(6) applied correctly according to the manufacturer's instructions and the physician's or the physician extenders' order; and
(7) used in conjunction with alternatives in an effort to reduce restraint use. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner.

Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

(b) The facility shall obtain written consent from the resident, the resident's responsible person as defined in Rule .0102 of this Subchapter, or legal representative for the resident to be restrained based on an order from the resident's physician or physician extender. The facility shall inform the resident, the resident's responsible person, or legal representative of the reason for the request, the benefits of restraint use, and the negative outcomes and alternatives to restraint use. The resident or the resident's legal representative or the responsible person if the resident is unable to consent to the use of restraints and there is no legal representative may accept or refuse restraints based on the information provided. Documentation shall consist of a statement signed by the resident or the resident's legal representative or the responsible person if the resident is unable to consent to the use of restraints and there is no legal representative indicating the signer has been informed, the signer's acceptance or refusal of restraint use and, if accepted, the type of restraint to be used and the medical indicators for restraint use.

Note: Potential negative outcomes of restraint use include incontinence, decreased range of motion, decreased ability to ambulate, increased risk of pressure ulcers, symptoms of withdrawal or depression, and reduced social contact.

(c) In addition to the requirements in Rules 13F .0801, .0802 and .0903 of this Subchapter regarding assessments and care planning, the resident assessment and care planning prior to application of restraints as required in Subparagraph (a)(5) of this Rule shall meet the following requirements:

(1) The assessment and care planning shall be implemented through a team process with the team consisting of at least a supervisor or personal care aide, a registered nurse, the resident and the resident's responsible person or legal representative. If the resident or resident's responsible person or legal representative is unable to participate, there shall be documentation in the resident's record that they were notified and declined the invitation or were unable to attend.

(2) The assessment shall include consideration of the following:

(A) medical symptoms that warrant the use of a restraint;

(B) how the medical symptoms affect the resident;

(C) when the medical symptoms were first observed;

(D) how often the symptoms occur;

(E) alternatives that have been provided and the resident's response; and

(F) the least restrictive type of physical restraint that would provide safety.

(3) The care plan shall include the following:

(A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained;

(B) the type of restraint to be used; and

(C) care to be provided to the resident during the time the resident is restrained.

(d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule:

(1) The order shall indicate:

(A) the medical need for the restraint based on the assessment and care plan;

(B) the type of restraint to be used;

(C) the period of time the restraint is to be used; and

(D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and no longer than two hours for releases.

(2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician or physician extender of the order within seven days.

(3) The restraint order shall be updated by the resident's physician or physician extender at least every three months following the initial order.

(4) If the resident's physician changes, the physician or physician extender who is to attend the resident shall update and sign the existing order.

(5) In an emergency, where the health or safety of the resident is threatened, the administrator or their designee, shall make the determination relative to the need for a restraint and its type and duration of use until a physician or physician extender is contacted. Contact with a physician shall be made within 24 hours and documented in the resident's record. For the purpose of this Rule, an "emergency" means a situation where there is a certain risk of physical injury or death to a resident.

(6) The restraint order shall be kept in the resident's record.

(e) All instances of the use of physical restraints and alternatives shall be documented by the facility in the resident's record and include the following:

(1) restraint alternatives that were provided and the resident's response;

(2) type of restraint that was used;

(3) medical symptoms warranting restraint use;

(4) the time the restraint was applied and the duration of restraint use;

(5) care that was provided to the resident during restraint use; and

(6) behavior of the resident during restraint use.

(f) Physical restraints shall be applied only by staff who have received training on the use of alternatives to physical restraint use and on the care of residents who are physically restrained according to Rule .0506 of this Subchapter and have been validated on the care of residents who are physically restrained and the use of care practices as alternative to restraints according to Rule .0504 of this Subchapter.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;
Amended Eff. April 1, 2025.

SECTION .1600 – STAR RATED CERTIFICATES

10A NCAC 13F .1601 DEFINITIONS

(a) As used in this Section, the following definitions shall apply:

(1) "Demerits" means points which are subtracted from a facility's star rating calculation as set forth in the requirements of Rule .1604 of this Section.

(2) "Merits" means points which are added to a facility's star rating calculation as set forth in the requirements of Rule .1604 of this Section.

(3) "Standard deficiency" means a citation issued by the Division of Health Service Regulation to a facility for failure to comply with licensure rules and statutes governing adult care homes and the non-compliance does not meet the criteria of a Type A1, Type A2 or Type B violation defined in G.S. 131D-34.

(4) "Star rated certificate" means a certificate issued by the Division of Health Service Regulation that includes a numerical score and corresponding number of stars issued to an adult care home based on the factors contained in G.S. 131D-10.

(5) "Star rating" means the numerical score and corresponding number of stars a facility receives based on the factors contained in G.S. 131D-10.

(6) "Star rating worksheet" means a document issued by the Division of Health Service Regulation which demonstrates how a facility's star rating was calculated in accordance with G.S. 131D-10(e) and Section .1600 of this Subchapter.

(7) "Type A1 violation" means the term as defined in G.S. 131D-34.

(8) "Type A2 violation" means the term as defined in G.S. 131D-34.

(9) "Type B violation" means the term as defined in G.S. 131D-34.

History Note: *Authority G.S. 131D-4.5; 131D-10;*
Eff. July 3, 2008;
Readopted Eff. August 1, 2025.

10A NCAC 13F .1602 ISSUANCE OF A STAR RATING

(a) A star rated certificate and worksheet shall be issued to a facility by the Division of Health Service Regulation within 45 days from the date that the Division mails the survey or inspection report to the facility, except when a request has been made by the facility under G.S. 131D-2.11 for informal dispute resolution. If a facility makes a request for informal dispute resolution, the Division of Health Service Regulation shall issue a star rating to the facility within 15 days from the date the Division mails the informal dispute decision to the facility.

(b) If the ownership of the facility changes, the star rating in effect at the time of the change of ownership shall remain in effect until the next annual or biennial survey or until a new certificate is issued pursuant to Rule .1604(b) of this Subchapter.

(c) The star rated certificate and worksheet the Division used to calculate the rating shall be displayed in a location visible to the public.

(d) The star rating worksheet shall be posted on the Division of Health Service Regulation website.

(e) The facility may contest the star rating by requesting a contested case hearing pursuant to Article 3 of G.S. 150B. The star rating and any subsequent star ratings shall remain in effect during any contested case hearing process.

History Note: *Authority G.S. 131D-4.5; 131D-10;*
Eff. July 3, 2008;
Readopted Eff. August 1, 2025.

10A NCAC 13F .1603 STATUTORY AND RULE REQUIREMENTS AFFECTING STAR RATED CERTIFICATES

The following Statutes and Rules comprise the standards that contribute to rated certificates:

(1) G.S. 131D-21 Declaration of Resident's Rights;
(2) Section .0300 of this Subchapter Physical Plant;
(3) Section .0400 of this Subchapter Staff Qualifications;
(4) Section .0700 of this Subchapter Admission and Discharge;
(5) Section .0800 of this Subchapter Resident Assessment and Care Plan;
(6) Section .0900 of this Subchapter Resident Care and Services;
(7) Section .1000 of this Subchapter Medications;
(8) Section .1300 of this Subchapter Special Care Units for Alzheimer's and Related Disorders;
(9) Section .1500 of this Subchapter Use of Physical Restraints and Alternatives; and
(10) Section .1800 of this Subchapter Infection Prevention and Control.

History Note: *Authority G.S. 131D-4.5; 131D-10;*
Eff. July 3, 2008;
Readopted Eff. August 1, 2025.

10A NCAC 13F .1604 RATING CALCULATION

(a) Ratings shall be based on:

(1) Inspections completed pursuant to G.S. 131D-2.11(a) and (a1);
(2) Statutory and Rule requirements listed in Rule .1603 of this Section;
(3) Type A1, Type A2, or uncorrected Type B penalty violations identified pursuant to G.S. 131D-34; and
(4) Other items listed in Subparagraphs (c)(1) and (c)(2) of this Rule.

(b) The initial rating a facility receives shall remain in effect until the next inspection. If an activity occurs which results in the assignment of additional merit or demerit points, a new certificate shall be issued pursuant to Rule .1602(a) of this Section.

(c) The rating shall be based on a 100 point scale. Beginning with the initial rating and repeating with each annual or biennial inspection, the facility shall be assigned 100 points and shall receive merits or demerits, which shall be added or subtracted from the 100 points, respectively. The merits and demerits shall be assigned as follows:

(1) Merit Points
  (A) If the facility corrects a standard deficiency of noncompliance with the statutes or rules listed in Rule .1603 of this Subchapter, the facility shall receive 1.25 merit points for each corrected deficiency;
  (B) If the facility corrects a citation for which a Type B violation was identified, the facility shall receive 1.75 merit points;
  (C) If the facility corrects a previously uncorrected Type B violation, the facility shall receive 1.75 merit points;
  (D) If the facility corrects the citation for which a Type A1 or Type A2 violation was identified, the facility shall receive 5 merit points;
  (E) If the facility corrects a previously uncorrected Type A1 or Type A2 violation, the facility shall receive 5 merit points;
  (F) If the facility's admissions have been suspended, the facility shall receive 5 merit points if the suspension is removed;
  (G) If the facility's license is restored to a full license after being downgraded to a provisional license, the facility shall receive 5 merit points;
  (H) If the facility participates in any quality improvement program pursuant to G.S. 131D-10, the facility shall receive 2.5 merit points;
  (I) If the facility establishes an ongoing resident council which meets at least quarterly, the facility shall receive .5 merit point;
  (J) If the facility establishes an ongoing family council which meets at least quarterly, the facility shall receive .5 merit point;
  (K) If the facility's designated on-site staff member who directs the facility's infection control activities in accordance with G.S. 131D-4.4A has completed the "Infection Control in Long Term Care Facilities" course offered by the University of North Carolina Statewide

Program for Infection Control and Epidemiology (SPICE) every two years, the facility shall receive .5 merit point;

(L) If the facility permanently installs a generator or has a contract with a generator provider to provide emergency power for essential functions of the facility, the facility shall receive 2 merit points. For purposes of this Rule, essential functions mean those functions necessary to maintain the health or safety of residents during power outages greater than 6 hours and include the fire alarm system, heating, lighting, refrigeration for medication storage, minimal cooking, elevators, medical equipment, computers, door alarms, special locking systems, sewage and well operation where applicable, sprinkler system, and telephones. If the facility has an existing permanently installed generator or an existing contract with a generator provider, the facility shall receive 1 merit point for maintaining the generator in working order or continuing the contract with a generator provider;

(M) If the facility installs automatic sprinklers in compliance with the North Carolina Building Code, and maintains the system in working order, the facility shall receive 3 merit points. If the facility has an existing automatic sprinkler, the facility shall receive 2 merit points for subsequent ratings for maintaining the automatic sprinklers in working order; and

(N) If the facility engages the services of a third-party company to conduct resident and family satisfaction surveys at least annually for the purpose of improving resident care, the facility shall receive 1 merit point. Resident and family satisfaction surveys shall not be conducted by any employees of the facility, or a third-party company affiliated with the facility. The satisfaction survey results shall be made available upon request and in a location accessible to residents and visitors in the facility.

(2) Demerit Points

(A) For each standard deficiency of noncompliance with the statutes or rules listed in Rule .1603 of this Subchapter, the facility shall receive a demerit of 2 points. The facility shall receive demerit points only once for citations in which the findings are identical to those findings used for another citation;

(B) For each citation of a Type A1 or Type A2 violation, the facility shall receive a demerit of 10 points, and if the Type A1 or Type A2 violation remains uncorrected as result of a follow-up inspection, the facility shall receive an additional demerit of 10 points;

(C) For each citation of a Type B violation, the facility shall receive a demerit of 3.5 points and if the Type B violation remains uncorrected as the result of a follow-up inspection, the facility shall receive an additional demerit of 3.5 points;

(D) If the facility's admissions are suspended, the facility shall receive a demerit of 10 points; however, if the facility's admissions are suspended pursuant to G.S. 131D-2.7, the facility shall not receive any demerit points;

(E) If the facility's license is downgraded to a provisional license pursuant to G.S. 131D-2.7, the facility shall receive a demerit of 10 points;

(F) If the facility receives a notice of revocation against its license pursuant to G.S. 131D-2.7, the facility shall receive a demerit of 31 points; and

(G) If the facility's license is summarily suspended pursuant to G.S. 131D-2.7, the facility shall receive a demerit of 31 points.

(d) Facilities shall be given a rating of zero to four stars depending on the score assigned pursuant to Paragraph (a), (b) or (c) of this Rule. Ratings shall be assigned as follows:

(1) Four stars shall be assigned to any facility whose score is 100 points or greater on two consecutive annual or biennial inspections;

(2) Three stars shall be assigned for scores of 90 to 99.9 points, or for any facility whose score is 100 points or greater on one annual or biennial inspection;

(3) Two stars shall be assigned for scores of 80 to 89.9 points;

(4) One star shall be assigned for scores of 70 to 79.9 points; and

(5) Zero stars shall be assigned for scores of 69.9 points or lower.

History Note: Authority G.S. 131D-4.5; 131D-10;
Eff. July 3, 2008;
Readopted Eff. August 1, 2025.

10A NCAC 13F .1605 CONTENTS OF STAR RATED CERTIFICATE

(a) The certificate shall contain a rating determined pursuant to Rule .1604 of this Subchapter.

(b) The certificate or accompanying worksheet from which the score is derived shall contain a breakdown of the point merits and demerits by the factors listed in Rules .1603 and .1604(c) of this Subchapter in a manner that the public can determine how the rating was assigned and the factors that contributed to the rating.

(c) The Division of Health Service Regulation shall issue the certificate pursuant to Rule .1602 of this Subchapter.

History Note: *Authority G.S. 131D-4.5; 131D-10;*
Eff. July 3, 2008;
Readopted Eff. August 1, 2025.

SECTION .1700 –ADMINISTRATOR CERTIFICATION AND RENEWAL

10A NCAC 13F .1701 CERTIFICATION OF ADMINISTRATOR

The administrator of an adult care home licensed on or after January 1, 2000, shall be certified by the Department under the provisions of G.S. 90, Article 20A.

History Note: *Authority G.S. 90-288.12; 131D-2.16; 131D-2.18; 131D-4.3; 143B-165;*
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Amended Eff. June 1, 2004;
Transferred and Recodified from 10A NCAC 13F .0401 Eff. February 29, 2016;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018.

10A NCAC 13F .1702 ADVERSE ACTION ON CERTIFICATION

(a) The Department shall deny, suspend, or revoke the certification of an administrator if the administrator or applicant administrator:

(1) has not completed the continuing education credits required by Rule .1703 of this Section;

(2) has been convicted by any jurisdiction of a felony unless rights of citizenship have been restored and all of the following have been considered and determined by the Department to allow certification:

(A) the date of conviction;

(B) the circumstances surrounding the committing of the crime, if known;

(C) the nexus between the criminal conduct of the person and the duties of an administrator; and

(D) the prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed;

(3) has been convicted by any jurisdiction of a misdemeanor unless all terms of the judgment imposed for said misdemeanor have been met and the following have been considered and determined by the Department to allow certification:

(A) the date of conviction;

(B) the circumstances surrounding the committing of the crime, if known;

(C) the nexus between the criminal conduct of the person and the duties of an administrator; and

(D) the prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed;

(4) was the administrator of an adult care home or family care home whose license was summarily suspended pursuant to G.S. 131D-2.7(c) or a notice of revocation of the facility's license was issued pursuant to G.S. 131D-2.7(b). In these circumstances, the Department shall take into consideration the length of time the administrator was serving in that capacity at the facility and the nexus between the reason for the summary suspension or revocation of the facility's license and the job duties of the administrator in deciding whether to deny, suspend, or revoke the certification of an administrator;

(5) is unable to perform as administrator with reasonable skill and safety to residents by reason of any observable or documented condition, such as dementia or other disease condition known to result in irreversible cognitive deterioration or drug or alcohol dependency, that impairs the individual in such a way that it endangers the health, safety, or welfare of residents;
(6) tested positive for a controlled substance or refused to consent to drug testing according to G.S. 131D-45;
(7) prior or subsequent to applying for administrator certification, has a finding on the North Carolina Health Care Personnel Registry pursuant to G.S. 131E-256; or
(8) fails to report any arrest or conviction for a felony or misdemeanor to the Department within ten days after such arrest or conviction.

(b) The Department shall suspend the certification of an administrator who has been arrested because of alleged criminal conduct, if the relationship between the alleged criminal conduct and the administrator's duties indicates a need to seek action in order to further protect facility residents pending adjudication by a court. Serving as an administrator while the administrator's certification is suspended shall be grounds for revocation of certification. Examples of criminal conduct the Department may consider in relation to the administrator's duties include fraud, physical assault, theft, abuse, neglect, exploitation, and drug diversion.

History Note: Authority G.S. 90-288.18; 131D-2.16; 131D-2.18; 131D-4.3; 143B-165;
Eff. April 1, 2017.

10A NCAC 13F. 1703 RENEWAL OF ADMINISTRATOR CERTIFICATION

(a) The Department shall renew an administrator's certification at the end of the year following the year of initial certification if the administrator submits documentation of completed coursework related to long term care management or the care of aged and disabled persons dated and issued by the course provider after certification. The required number of hours of coursework shall be prorated by the Department based on 30 hours of required continuing education biennially and the number of months from the date of the administrator's initial certification until December 31 of the next year following issuance.

(b) The Department shall continue to renew an administrator's certification biennially, pursuant to G.S. 90-288.15, based on an expiration date of December 31. For each renewal following initial renewal the administrator shall submit documentation totaling 30 hours of completed coursework related to long term care management or the care of aged and disabled persons dated and issued by the course provider within the current two-year certification period and a renewal fee of thirty dollars ($30.00) pursuant to G.S. 90-288.15.

(c) For the purposes of this Rule, examples of coursework related to long term care management or the care of aged and disabled persons include financial management, human resource management, medication administration, dementia care, diabetic care, managing aggressive behaviors, and infection control.

History Note: Authority G.S. 90-288.15; 90-288.15A; 131D-2.16; 131D-4.3; 143B-165;
Eff. April 1, 2017.

SECTION .1800 - INFECTION PREVENTION AND CONTROL

10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES

(a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement infection prevention and control policies and procedures consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control. The Department shall approve a set of policies and procedures for infection prevention and control consistent with the federal CDC published guidelines on infection prevention and control that shall be made available on the Division of Health Service Regulation, Adult Care Licensure Section website at https://info.ncdhhs.gov/dhsr/acls/acforms.html at no cost. The facility shall either:

(1) utilize the set of policies and procedures for infection prevention and control approved by the Department;
(2) develop policies and procedures for infection prevention and control that are consistent with the set of Department approved policies and procedures; or
(3) develop policies and procedures for infection prevention and control that are based on nationally recognized standards in infection prevention and control that are consistent with the federal CDC published guidelines on infection prevention and control.

(b) The facility's infection and control policies and procedures shall be implemented by the facility and shall address the following:

(1) Standard and transmission-based precautions, including:
  (A) respiratory hygiene and cough etiquette;
  (B) environmental cleaning and disinfection;
  (C) reprocessing and disinfection of reusable resident medical equipment;
  (D) hand hygiene;
  (E) accessibility and proper use of personal protective equipment (PPE); and
  (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions;

(2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section;

(3) Measures for the facility to consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents, and visitors for signs of illness; and use of source control as tolerated by the residents; and

(4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak.

(c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's infection prevention and control policies and procedures, and when issued, guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat that have been issued in writing by the North Carolina Department of Health and Human Services or local health department.

(d) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(4), the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs (b)(1) through (b)(2) of this Rule.

(e) The policies and procedures listed in Paragraph (b) of this Rule shall be maintained in the facility and accessible to staff working at the facility.

History Note: *Authority G.S. 131D-2.16; 131D-4.4A; 143B-165;*
Emergency Adoption Eff. October 23, 2020;
Temporary Adoption Eff. December 30, 2020;
Eff. August 23, 2022.

10A NCAC 13F .1802 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK

(a) The facility shall report suspected or confirmed communicable diseases and conditions within the time period and in the manner determined by the Commission for Public Health as specified in 10A NCAC 41A .0101 and 10A NCAC 41A .0102(a)(1) through (a)(3), which are hereby incorporated by reference, including subsequent amendments.

(b) The facility shall provide the residents and their representative(s) and staff with an initial notice within 24 hours following confirmation by the local health department of a communicable disease outbreak. The facility, in its initial notification to residents and their representative(s), shall:

(1) not disclose any personally identifiable information of the residents or staff;

(2) provide information on the measures the facility is taking to prevent or reduce the risk of transmission, including whether normal operations of the facility will change; and

(3) provide information to the resident(s) concerning measures they can take to reduce the risk of spread or transmission of infection.

(c) Following the initial notice to residents and their representative(s) of a communicable disease outbreak, the facility shall provide the following:

(1) an update every two weeks until the communicable illness within the facility has resolved, as determined by the local health department; and

(2) an update that the communicable illness within the facility has resolved, as determined by the local health department.

History Note: Authority G.S. 131D-2.16; 131D-4.4B; 131D-4.5; 143B-165;
Emergency Adoption Eff. October 23, 2020;
Temporary Adoption Eff. December 30, 2020;
Eff. August 23, 2022.

SUBCHAPTER 13G – LICENSING OF FAMILY CARE HOMES

SECTION .0100 - DEFINITIONS

10A NCAC 13G .0101 DEFINITIONS

History Note: Authority G.S. 131D-2; 143B-153;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1987; April 1, 1984; June 26, 1980;
Repealed Eff. July 1, 2005.

10A NCAC 13G .0102 LIST OF DEFINITIONS

In addition to the definitions set forth in G.S. 131D-2.1, the following definitions shall apply throughout this Subchapter:

(1) "Abuse" as defined in G.S. 131D-2.1.
(2) "Activities of daily living" means bathing, dressing, personal hygiene, ambulation, or locomotion, transferring, toileting, and eating.
(3) "Acute care needs" means symptoms or a condition that develops quickly and is not a part of the resident's baseline health or mental health status or is a change or worsening in the symptoms of a resident's chronic condition, which may have a slower onset and worsen over time.
(4) "Administrator" means the term as defined in G.S. 90-288.13 and G.S. 131D-2.1.
(5) "Adult care home" means the term as defined in G.S. 131D-2.1.
(6) "Alternative examination" means a test developed and administered by the Department to meet the educational requirements of an activity director or supervisor-in-charge for those applicants who do not possess a high school diploma or General Education Diploma (G.E.D.) prior to September 1, 2024.
(7) "Aide duty" means time spent by qualified staff providing assistance with activities of daily living, medication administration, or supervision of residents as determined by the resident's assessment, care plan, physician's orders, and current symptoms.
(8) "Ambulatory" means able to respond and evacuate a facility without physical or verbal prompting from staff or another person.
(9) "Department" means the North Carolina Department of Health and Human Services.
(10) "Discharge" means a resident's termination of their residency at the adult care home, resulting in the resident's move to another location.
(11) "Exploitation" means the term as defined in G.S. 131D-2.1.
(12) "Facility" means a licensed family care home.
(13) "Family care home" means the term as defined in G.S. 131D-2.1.
(14) "First shift" means between the hours of 7:01 a.m. and 3:00 p.m.
(15) "Food service duties" means tasks performed by staff related to serving meals to residents, including assisting with food preparation, arranging and setting the dining tables, serving food and beverages, and cleaning the dining room after meal service is complete.
(16) "Housekeeping duties" means tasks performed by staff such as cleaning and sanitizing facility common areas and resident rooms.
(17) "Legal representative" means a person authorized by state or federal law (law including, but not limited to, power of attorney representative payee) to act on behalf of the resident to support the resident in decision-making; access medical, social, or other personal information of the resident; manage financial matters or receive notifications.

(18) "Long-term care" means a continuum of care and services available in an individual's community that provides the care and support required during a persistent or chronic health condition, such as when a person is unable to independently perform some or all activities of daily living or requires supervision due to physical or cognitive impairment.
(19) "Medication aide" means an individual who administers medications to residents and meets all requirements as set forth in Rule .0403 of this Subchapter.
(20) "Neglect" means the term as defined in G.S. 131D-2.1.
(21) "Non-ambulatory" means not able to respond and evacuate a facility without physical or verbal prompting from staff or another person.
(22) "On-call" means able to be contacted by two-way telecommunication.
(23) "On-duty" in reference to an administrator means the administrator is on-site and directly responsible for the day-to-day operations of a facility. "On-duty" in reference to a supervisor-in-charge means a supervisor-in-charge designated by the facility as required in Rule .0402 of this Subchapter and who is on-site and directly responsible for the day-to-day operations of a facility under the direction and supervision of the administrator.
(24) "Personal care aide" means a staff member who performs personal care services as defined by G.S. 131D-2.1.
(25) "Physical restraint" means any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily, and which restricts freedom of movement or normal access to one's body.
(26) "Physician extender" means a licensed physician assistant or licensed nurse practitioner.
(27) "Resident" means the term as defined in G.S. 131D-2.1.
(28) "Responsible person" means a person chosen by the resident to act on their behalf to support the resident in decision-making; have access to medical, social, or other personal information of the resident; manage financial matters; or receive notifications.
(29) "Second shift" means between the hours of 3:01 p.m. and 11:00 p.m.
(30) "Staff" means any person who performs duties as an employee, paid or unpaid, on behalf of the family care home.
(31) "Supervision" means oversight, monitoring, and interventions implemented by the facility for the purpose of mitigating the risk of an accident, incident, illness, or injury to a resident to ensure the health, safety, and welfare of the resident and other residents.
(32) "Supervisor-in-charge" means an individual responsible for the total operation of a family care home in the absence of the administrator and under the direction and supervision of the administrator as described in Rule .0402 of this Subchapter.
(33) "Third shift" means between the hours of 11:01 p.m. and 7:00 a.m.

History Note: *Authority G.S. 131D-2.16; 143B-153;*
Eff. September 1, 2024.

SECTION .0200 - LICENSING

10A NCAC 13G .0201 DEFINITIONS

The following definitions shall apply throughout this Section:

(1) "Person" means an individual; a trust or estate; a partnership; a corporation; or any grouping of individuals, each of whom owns five percent or more of a partnership or corporation, who collectively own a majority interest of either a partnership or a corporation.
(2) "Owner" means any person who has or had legal or equitable title to or a majority interest in an adult care home.
(3) "Affiliate" means any person that directly or indirectly controls or did control an adult care home or any person who is controlled by a person who controls or did control an adult care home. In addition, two or more adult care homes who are under common control are affiliates.
(4) "Principal" means any person who is or was the owner or operator of an adult care home, an executive officer of a corporation that does or did own or operate an adult care home, a general partner of a partnership that does or did own or operate an adult care home, or a sole proprietorship that does or did own or operate an adult care home.

(5) "Indirect control" means any situation where one person is in a position to act through another person over whom the first person has control due to the legal or economic relationship between the two.

History Note: Authority G.S. 131D-2.4; 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .0202 THE LICENSE

(a) Except as otherwise provided in G.S. 131D-2.4, the Department of Health and Human Services shall issue a family care home license to any person who submits the application material according to Rule .0204 of this Section and the Department determines that the applicant complies with the provisions of all State adult care home licensure statutes and rules of this Subchapter. All applications for a new license shall disclose the names of individuals who are co-owners, partners, or shareholders holding an ownership or controlling interest of five percent or more of the applicant entity.
(b) The license shall be posted in a publicly viewable place in the home.
(c) When a provisional license is issued according to G.S. 131D-2.7, the administrator shall post the provisional license and a copy of the notice from the Division of Health Service Regulation identifying the reasons for it, in a publicly viewable place in the home and in place of the full license.
(d) The license is not transferable or assignable.
(e) A family care home shall be licensed only as a family care home and not for any other level of care or licensable entity or service. The license shall be terminated when the home is licensed to provide a higher level of care or a combination of a higher level of care and family care home level of care.

History Note: Authority G.S. 131D-2.4; 131D-2.7; 131D-2.16; 131D-4.5; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Temporary Amendment Eff. January 1, 1998;
Amended Eff. April 1, 1999;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005;
Readopted Eff. June 1, 2020.

10A NCAC 13G .0203 PERSONS NOT ELIGIBLE FOR NEW ADULT CARE HOME LICENSES

History Note: Authority G.S. 131D-2.4; 131D-2.5; 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Expired Eff. March 1, 2019 pursuant to G.S. 150B-21.3A.

10A NCAC 13G .0204 APPLYING FOR A LICENSE TO OPERATE A HOME NOT CURRENTLY LICENSED

(a) An application for a license to operate a family care home for adults in an existing building where no alterations are necessary as determined by the Construction Section of the Division of Health Service Regulation or a family care home that is to be constructed, added to, or renovated shall be made at the county department of social services in the county where the licensed family care home will be located.
(b) The applicant shall submit the following material to the county department of social services for submission to the Division of Health Service Regulation within 10 business days of receipt by the county department of social services:

(1) the Initial Licensure Application that is available online at https://info.ncdhhs.gov/dhsr/acls/pdf/acchgapp.pdf at no cost and includes the following:

(A) contact person, facility site and mailing addresses, and administrator;
(B) operation disclosure including names and contact information of licensee, management company, and building owner;
(C) ownership disclosure including names and contact information of owners, principals, affiliates, shareholders, and members; and
(D) bed capacity;

(2) an approval letter from the local zoning jurisdiction for the proposed location;
(3) a photograph of each side of the existing structure and at least one of each of the interior spaces if an existing structure;
(4) a set of blueprints or a floor plan of each level indicating the following:
(A) the layout of all rooms;
(B) the room dimensions (including closets);
(C) the door widths (exterior, bedroom, bathroom, and kitchen doors);
(D) the window sizes and window sill heights;
(E) the type of construction;
(F) the use of the basement and attic; and
(G) the proposed resident bedroom locations including the number of occupants and the bedroom and number (including the ages) of any non-resident who will be residing within the home;

(5) a cover letter prepared by the adult home specialist of the county department of social services stating the following:
(A) the prospective home site address;
(B) the name of the contact person (including address, telephone numbers, email address); and
(C) the name and address of the applicant (if different from the contact person); and

(6) a non-refundable license fee as required by G.S. 131E-272.

(c) Issuance of a family care home license shall be based on the following:
(1) completion of and approval in accordance with Subparagraphs (b)(1) through (b)(6) of this Rule;
(2) the Division of Health Service Regulation's Construction Section's recommendation of licensure based on compliance with rules in Section .0300 of this Subchapter;
(3) a compliance history review of the facility and its principals and affiliates according to G.S. 131D-2.4;
(4) approval by the Adult Care Licensure Section of the facility's operational policies and procedures based on compliance with the rules of this Subchapter; and
(5) the facility's demonstration of compliance with Adult Care Home statutes and rules of this Subchapter as determined by a pre-licensing survey of the facility by the Adult Care Licensure Section.

(d) The Adult Care Licensure Section shall notify in writing the applicant licensee and the county department of social services of the decision to license or not to license the adult care home based on compliance with adult care home statutes and the rules of this Subchapter within 14 days from the decision to license or not to license the facility.

History Note: Authority G.S. 131D-2.4; 131D-2.5; 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1987; April 1, 1984;
ARRC Objection Lodged November 14, 1990;
Amended Eff. May 1, 1991;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. July 1, 2005; July 1, 2004;
Readopted Eff. June 1, 2020.

10A NCAC 13G .0205 APPLICATION TO LICENSE A NEWLY CONSTRUCTED OR RENOVATED BUILDING

History Note: Authority G.S. 131D-2; 143B-165; S.L. 2002-0160;

Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1984;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004;
Repealed Eff. July 1, 2005.

10A NCAC 13G .0206 CAPACITY

(a) Pursuant to G.S. 131D-2.1(9), family care homes shall have a capacity of two to six residents. For the purposes of this Rule, "capacity" means the maximum number of residents permitted to live in a licensed family care home in accordance with the North Carolina Building Code and the evacuation capability of each resident.
(b) The total number of residents shall not exceed the number shown on the license. The license shall indicate the facility's capacity for ambulatory and non-ambulatory individuals permitted to live in the facility. For the purposes of this Rule, "ambulatory" means the individual is able to respond and evacuate from the facility without verbal or physical assistance from others in the event of an emergency. "Non-ambulatory" means the individual is not able to respond and evacuate from the facility without verbal or physical assistance from others in the event of an emergency.
(c) A request for an increase in capacity by adding rooms, remodeling, or without building modifications shall be made to the county department of social services and submitted to the Division of Health Service Regulation Construction Section and shall include two copies of blueprints or floor plans. One plan shall show the existing building with the current use of rooms, and the second plan showing the addition, remodeling, or change in use of spaces, and showing the use of every room. If new construction, the second plan shall show how the addition will be tied into the existing building and all proposed changes in the structure.
(d) When licensed facilities increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire facility shall meet all current fire safety regulations required by city ordinances or county building inspectors.
(e) The licensee or the licensee's designee shall notify the Division of Health Service Regulation Adult Care Licensure Section if the evacuation capabilities of the residents changes and the facility no longer complies with the facility's licensed capacity as listed on the facility's license, or of the addition of any non-resident who will be living within the facility.
(f) If there is a temporary change in the capacity of the facility due to a resident's short term illness or condition that renders the resident temporarily non-ambulatory, such as end of life condition, the licensee or the licensee's designee shall immediately notify the Division of Health Service Regulation Construction Section upon the knowledge of the change in the resident's ambulatory status.

History Note: *Authority G.S. 131D-2.4; 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; July 1, 1990; April 1, 1984; January 1, 1983;
Readopted Eff. April 1, 2025.

10A NCAC 13G .0207 CHANGE OF LICENSEE

Prior to the sale of a family care home business, the current and prospective licensee shall meet the requirements of this Rule.

(1) The current licensee shall provide written notification of a planned change of licensee to the Division of Health Service Regulation, the county department of social services, and the residents or their responsible persons at least 30 days prior to the date of the planned change of licensee.
(2) The prospective licensee shall submit the following license application material to the Division of Health Service Regulation:
    (a) the Change Licensure Application for Family Care Home (2 to 6 Beds) that is available on the internet website, https://info.ncdhhs.gov/dhsr/acls/pdf/fcchgapp.pdf at no cost and includes the following:
        (i) facility, administrator and building owner information;
        (ii) operation disclosure including new licensee information and management company, if any; and

(iii) ownership disclosure including new owners, principles, affiliates, shareholders, and members;

(b) a fire and building safety inspection report from the local fire marshal dated within the past 12 months;

(c) a sanitation report from the sanitation division of the county health department dated within the past 12 months; and

(d) a nonrefundable license fee as required by G.S. 131D-2.5.

History Note: Authority G.S. 131D-2.4; 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1984;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004;
Readopted Eff. January 1, 2020.

10A NCAC 13G .0208 RENEWAL OF LICENSE

(a) The licensee shall file a license renewal application annually on a calendar year basis on the forms provided by the Department at no cost with a nonrefundable annual license fee according to G.S. 131D-2.5. The renewal application includes the following:

(1) contact person, facility site and mailing address, and administrator;

(2) operation disclosure including names and contact information of the licensee, management company, and building owner;

(3) ownership disclosure including names and contact information of owners, principals, affiliates, shareholders, and members holding an ownership or controlling interest of five percent or more of the applicant entity;

(4) bed capacity; and

(5) population and census data.

(b) In determining whether to renew a license under G.S. 131D-2.4, the Department shall take into consideration at least the following:

(1) the compliance history of the applicant facility with the provisions of all State adult care home licensure statutes and rules of this Subchapter;

(2) the compliance history of the owners. principals and affiliates of the applicant facility in operating other adult care homes in the State;

(3) the extent to which the conduct of the licensee, including owners, principals, affiliates, and persons and those with indirect control as defined in Rule .0201 of this Section, is likely to affect the quality of care at the applicant facility; and

(4) the hardship on residents of the applicant facility if the license is not renewed.

(c) When violations of licensure rules or statutes are documented by the Department and have not been corrected by the facility prior to license expiration, the Department shall either approve a continuation or extension of a plan of correction, issue a provisional license, or deny the license.

History Note: Authority G.S. 131D-2.4; 131D-2.16; 131D-4.5; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. December 1, 1992; July 1, 1990; April 1, 1987; April 1, 1984;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Readopted Eff. June 1, 2020.

10A NCAC 13G .0209 CONDITIONS FOR LICENSE RENEWAL

History Note: Authority G.S. 131D-2.4; 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Repealed Eff. June 1, 2020.

10A NCAC 13G .0210 TERMINATION OF LICENSE

History Note: Authority G.S. 131D-2; 143B-153;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1984;
Temporary Amendment Eff. January 1, 1998;
Amended Eff. April 1, 1999;
Repealed Eff. July 1, 2005.

10A NCAC 13G .0211 CLOSING OF HOME

If a licensee plans to close a family care home, the licensee shall provide written notification of the planned closing to the Division of Health Service Regulation, the county department of social services and the residents or their responsible persons at least 30 days prior to the planned closing. Written notification shall include date of closing and plans made for the move of the residents.

History Note: Authority G.S. 131D-2.4; 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1984;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .0212 DENIAL AND REVOCATION OF LICENSE

(a) A license may be denied by the Division of Health Service Regulation for failure to comply with the rules of this Subchapter.
(b) Denial of a license by the Division of Health Service Regulation shall be effected by mailing to the applicant licensee, by registered mail, a notice setting forth the particular reasons for such action.
(c) A license may be revoked by the Division of Health Service Regulation in accordance with G.S. 131D-2.7(b) and G.S. 131D-29.
(d) When a facility receives a notice of revocation, the administrator shall inform each resident and the resident's responsible person in writing of the notice and the basis on which it was issued within five calendar days of the notice of revocation being received by the licensee of the facility.

History Note: Authority G.S. 131D-2.7; 131D-2.16; 131D-4.3; 131D-29; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984; May 1, 1981;
Temporary Amendment Eff. January 1, 1998;
Amended Eff. April 1, 1999;
Readopted Eff. June 1, 2020.

10A NCAC 13G .0213 APPEAL OF LICENSURE ACTION

History Note: Authority 131D-2.4; 131D-2.16; 143B-165; 150B-23;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1984;
Repealed Eff. June 1, 2020.

10A NCAC 13G .0214 SUSPENSION OF ADMISSIONS

History Note: Authority G.S. 131D-2.7;

Eff. January 1, 1982;
Amended Eff. July 1, 1990;
Repealed Eff. January 1, 2020.

10A NCAC 13G .0215 APPEAL OF SUSPENSION OF ADMISSIONS

History Note: *Authority G.S. 131D-2.7;*
Eff. January 1, 1982;
Amended Eff. January 4, 1994;
Expired Eff. March 1, 2019 pursuant to G.S. 150B-21.3A.

10A NCAC 13G .0216 ADMINISTRATIVE PENALTY DETERMINATION PROCESS

History Note: *Authority G.S. 131D-34;*
Eff. December 1, 1992;
Amended Eff. March 1, 1995; December 1, 1993;
Temporary Amendment Eff. December 8, 1997;
Amended Eff. April 1, 1999;
Repealed Eff. October 1, 2016.

SECTION .0300 - THE BUILDING

10A NCAC 13G .0301 APPLICATION OF PHYSICAL PLANT REQUIREMENTS
A family care home shall meet the following physical plant requirements:

(1) New construction and existing buildings proposed for use as a Family Care Home shall comply with the requirements of this Section.
(2) Except where otherwise specified, existing licensed facilities or portions of existing licensed facilities shall meet the licensure and code requirements in effect at the time of licensure, construction, change in service, change in bed capacity, addition, modification, renovation, or alteration.
(3) New additions, alterations, modifications, and repairs shall meet the requirements of this Section.
(4) The Division may grant an equivalency to allow alternate methods, procedures, design criteria, or functional variation from the requirements of this Rule and the rules contained in this Section. The equivalency may be granted by the Division when the owner or his appointed representative submits a written equivalency request to the Division that states the following:
 (a) the rule citation and the rule requirement that will not be met because strict conformance with current requirements would be:
  (i) impractical;
  (ii) unable to be met due to extraordinary circumstances. For the purpose of this Rule, "extraordinary circumstances" means situations that are unexpected and beyond the control of the facility; or
  (iii) unable to be met due to new programs.
 (b) the justification for the equivalency; and
 (c) how the proposed equivalency meets the intent of the corresponding rule requirement.
(5) In determining whether to grant an equivalency request, the Division shall consider whether the request will reduce the safety and operational effectiveness of the facility. The facility shall maintain a copy of the approved equivalency issued by the Division.
(6) Where rules, codes or standards have any conflict, the more stringent requirement shall apply.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. July 1, 2005;
Readopted Eff. April 1, 2025.

10A NCAC 13G .0302 DESIGN AND CONSTRUCTION
(a) A building licensed for the first time as a family care home, or a licensed family care home relicensed after the license is terminated for more than 60 days, shall meet the requirements of the North Carolina State Building Code:

Residential Code in effect at the time of licensure or relicensure. Additionally, facilities requesting licensure or relicensure for four to six residents shall meet the North Carolina State Building Code: Building Code, Licensed Residential Care Facilities Section in effect at the time of licensure or relicensure. The North Carolina State Building Codes, which are hereby incorporated by reference, including all subsequent amendments and editions, may be purchased from the International Code Council online at https://shop.iccsafe.org/ at a cost of eight hundred fifty-eight dollars ($858.00) or accessed electronically free of charge at https://codes.iccsafe.org/codes/north-carolina.

(b) New construction, additions, alterations, modifications, and renovations to buildings shall meet the requirements of the North Carolina State Building Code: Residential Code, and the North Carolina State Building Code: Building Code, Licensed Residential Care Facilities Section at the time of construction, alteration, modifications, and renovations.

(c) A family care home shall not offer services for which the facility was not planned, constructed, equipped, or maintained.

(d) An existing building converted from another use to a family care home shall meet all the requirements of Paragraph (a) of this Rule.

(e) An existing licensed facility that plans to have new construction, remodeling or physical changes done to the facility shall have drawings submitted by the owner or his appointed representative to the Division of Health Service Regulation for review and approval prior to commencement of the work to ensure compliance with the rules established in this Section.

(f) If the building is two stories in height, it shall meet the following requirements:

(1) each floor shall be less than 2500 square feet in area if existing construction or, if new construction, shall not exceed the allowable area for Group R-4 occupancy in the North Carolina State Building Codes;

(2) elderly or disabled persons are not to be housed on any floor above or below grade level. For the purpose of this rule, "elderly" persons mean any person who meets the term as defined in G.S. 131D-2.1. For the purpose of this rule, "disabled" persons mean any person who meets the term "person with a disability" as defined in G.S. 168A-3;

(3) required resident facilities are not to be located on any floor above or below grade level; and

(4) a complete fire alarm system meeting the requirements of the National Fire Protection Association 72, NFPA 72: National Fire Alarm and Signaling Code, which is hereby incorporated by reference, including all subsequent amendments and editions. Copies of this code may be obtained from the National Fire Protection Association online at http://www.nfpa.org/catalog/ or accessed electronically free of charge at https://www.nfpa.org/codes-and-standards/all-codes-and-standards/list-of-codes-and-standards/detail?code=72. For the purpose of this Rule, a "complete fire alarm system" is a system that consists of components and circuits arranged to monitor and annunciate the status of fire alarm and supervisory signal-initiating devices and to initiate the appropriate response to those signals. Pull stations shall be installed on each floor at each exit. Sounding devices that are audible throughout the building shall be provided on each floor. The fire alarm system shall be able to transmit an automatic signal to the local emergency fire department dispatch center that is legally committed to serving the area in which the facility is located. The alarm shall be transmitted either directly to a fire department or through a third-party service that shall transmit the alarm to the fire department. The method used to transmit the alarm shall be in accordance with local ordinances.

(g) The basement and the attic shall not be used for storage or sleeping.

(h) The ceiling height throughout the family care home shall be at least seven and one-half feet from the floor.

(i) In facilities licensed on or after April 1, 1984, all required resident areas shall be on the same floor level. Steps and ramps between levels are not permitted.

(j) The following shall have door widths a minimum of two feet and six inches:

(1) the kitchen;

(2) dining rooms;

(3) living rooms;

(4) bedrooms; and

(5) bathrooms.

(k) All windows that are designed to be operable shall be maintained operable.

(l) The local code enforcement official shall be consulted before starting any construction or renovations for information on required permits and construction requirements.

(m) The building shall meet sanitation requirements set forth in 15A NCAC 18A .1600, Rules Governing the Sanitation of Residential Care Facilities, which are hereby incorporated by reference, including subsequent amendments and editions. Copies of these Rules may be accessed online free of charge at https://www.oah.nc.gov/.
(n) The facility shall maintain and have available for review current sanitation and fire safety inspection reports.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1984; January 1, 1983;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. July 1, 2005; June 1, 2004;
Readopted Eff. April 1, 2025.

10A NCAC 13G .0303 LOCATION

(a) A family care home shall be in a location approved by local zoning boards.
(b) The home shall be located so that hazards to the occupants are minimized.
(c) The site of the home shall:

(1) be accessible by streets, roads and highways and be maintained for motor vehicles and emergency vehicle access;
(2) be accessible to fire fighting and other emergency services;
(3) have a water supply, sewage disposal system, garbage disposal system and trash disposal system approved by the local health department having jurisdiction;
(4) meet all local ordinances; and
(5) be free from exposure to pollutants known to the applicant or licensee.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; July 1, 1990; April 1, 1984;
Recodified from 10A NCAC 13G .0301 Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .0304 LIVING ARRANGEMENT

A family care home shall provide living arrangements to meet the individual needs of the residents, the live-in staff and other live-in persons.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 1984;
Recodified from 10A NCAC 13G .0303 Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .0305 LIVING ROOM

(a) Family care homes licensed on or after April 1, 1984 shall have a living room or area a minimum of 200 square feet. For the purposes of this Rule, a "living room" is a space enclosed by walls used for social activities, such as reading, talking or watching television. For the purpose of this Rule, a "living area" is a space within the facility that may be opened to adjacent spaces and is designated to be used for social activities, such as reading, talking or watching television.
(b) All living rooms or areas shall have at least one operable window meeting the North Carolina State Building Code: Residential Code to view outdoors, and be lighted to provide 30 foot-candles of light at floor level.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;

Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; July 1, 1990; April 1, 1984;
Recodified from 10A NCAC 13G .0304 Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019;
Amended Eff. April 1, 2025.

10A NCAC 13G .0306 DINING ROOM OR DINING AREA

(a) Family care homes licensed on or after April 1, 1984 shall have a dining room or dining area a minimum of 120 square feet. For the purpose of this Rule, a "dining room" is a space enclosed by walls used for eating meals. For the purpose of this Rule, a "dining area" is a space within the facility that may be opened to adjacent spaces and is designated to be used for eating meals. The dining room or dining area may be used for other activities during the day.
(b) When the dining area is combined with a kitchen to form an eat-in kitchen, an area five feet wide in front of sinks, kitchen appliances, and any kitchen islands used for food preparation, shall be work space for the kitchen. The work space shall not be included as part of the square footage for the dining area.
(c) The dining room or dining area shall have at least one operable window meeting the North Carolina State Building Code: Residential Code to view the outdoors, or a door unit with a vision panel directly to the outside. The dining room or dining area shall be lighted to provide 30 foot-candles of light at floor level.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; July 1, 1990; April 1, 1984;
Recodified from 10A NCAC 13G .0305 Eff. July 1, 2005;
Readopted Eff. April 1, 2025.

10A NCAC 13G .0307 KITCHEN

(a) The kitchen in a family care home shall have space for the preparation and preservation of food and the washing of dishes.
(b) The cooking unit shall be mechanically ventilated to the outside. If the cooking unit is unvented, a recirculating fan shall be provided with a filter required by manufacturers' instructions for ventless use.
(c) The kitchen shall have floors that are water-resistant and slip-resistant.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Amended Eff. April 22, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 1984;
Recodified from 10A NCAC 13G .0306 Eff. July 1, 2005;
Readopted Eff. April 1, 2025.

10A NCAC 13G .0308 BEDROOMS

(a) There shall be bedrooms in number and size to meet the individual needs according to age and sex of the residents, the administrator or supervisor-in-charge, other live-in staff, and other persons living in a family care home. Residents shall not share bedrooms with staff or other live-in non-residents.
(b) Only rooms authorized by the Division of Health Service Regulation as bedrooms shall be used for bedrooms.
(c) A room where access is through a bathroom, kitchen, or another bedroom shall not be approved for a resident's bedroom.
(d) Private resident bedrooms shall provide not less than 100 square feet of occupiable floor area, excluding accessory areas such as vestibules, closets, wardrobes, or bathrooms. For the purpose of this Rule, a "private resident bedroom" is a resident bedroom occupied by one resident.
(e) Semi-private resident bedrooms shall provide not less than 80 square feet of occupiable floor area per bed, excluding accessory areas such as vestibules, closets, wardrobes, or bathrooms. For the purpose of this Rule, a "semi-private resident bedroom" is a resident bedroom occupied by two residents.

(f) The total number of residents assigned to a bedroom shall not exceed the number authorized by the Division of Health Service Regulation for that particular bedroom.
(g) A bedroom shall not be occupied by more than two residents.
(h) A resident bedroom shall have one or more operable windows meeting the requirements of the North Carolina State Building Code: Residential Code for emergency egress, and be lighted to provide 30 foot-candles of light at floor level. The window area shall not be less than eight percent of the floor space, and be equipped with insect-proof screens. Windows in resident bedrooms shall have a maximum of 44 inch sill height.
(i) A resident bedroom shall provide one closet or wardrobe per resident. Closets or wardrobes shall have clothing storage space of not less than 48 cubic feet per bed, approximately two feet deep by three feet wide by eight feet high, of which one-half of this space shall be for hanging with an adjustable height hanging bar.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; July 1, 1990; April 1, 1984;
Recodified from 10A NCAC 13G .0307 Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019;
Amended Eff. April 1, 2025.

10A NCAC 13G .0309 BATHROOM
(a) Family care homes licensed on or after April 1, 1984, shall have one full bathroom for five or fewer persons, including live-in staff. For the purpose of this Rule, a "full bathroom" is a room containing a sink, toilet, and a bathtub, shower, spa tub, or similar bathing fixture.
(b) Bathrooms with two or more toilets shall have privacy partitions or curtains for each toilet. Bathtubs, showers, spas, or similar bathing fixtures shall have privacy partitions or curtains. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities.
(c) Entrances to bathrooms shall not be through a kitchen, another person's bedroom, or another bathroom.
(d) Residents' bathrooms shall be located so that there is no more than 40 feet from a resident's bedroom door to a resident use bathroom door.
(e) Toilets, bathtubs, showers, spas, and similar bathing fixtures shall have hand grips meeting the following requirements:
(1) be mechanically fastened or anchored to the walls;
(2) be located to help residents in entering and exiting bathtubs, showers, spas, or similar bathing fixtures; and
(3) be on the wall adjacent to toilets.
(f) Nonskid surfacing or strips must be installed in bathtubs, showers, spas, and similar bathing fixtures.
(g) Bathrooms shall meet the following requirements:
(1) be lighted to provide 30 foot-candles of light at floor level;
(2) have an exhaust system per the North Carolina State Building Code: Residential Code. Exhaust vents shall vent directly to the outdoors; and
(3) have floors that are water-resistant and slip-resistant.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; July 1, 1990; April 1, 1984;
Recodified from 10A NCAC 13G .0308 Eff. July 1, 2005;
Readopted Eff. April 1, 2025.

10A NCAC 13G .0310 STORAGE AREAS
(a) Storage areas shall be adequate in size and number for separate storage of clean linens, soiled linens, food and food service supplies, and household supplies and equipment.
(b) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be supervised while in use.

History Note: Authority G.S. 131D-4.5; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1987; April 1, 1984;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Recodified from 10A NCAC 13G .0309 Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .0311 CORRIDOR

(a) Corridors shall be a minimum clear width of three feet in family care homes.
(b) Corridors shall be lighted with night lights providing 1 foot-candle power at the floor.
(c) Corridors shall be free of all equipment and other obstructions.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 1984;
Recodified from 10A NCAC 13G .0310 Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .0312 OUTSIDE ENTRANCE AND EXITS

(a) In family care homes, floor levels shall have at least two outside entrances/exits that are so located and constructed to minimize the possibility that both outside entrances/exits from the facility may be blocked by a fire or other emergency condition. Exiting through another resident's bedroom is not permitted.
(b) At least one outside entrance/exit door shall be a minimum width of three feet and another shall be a minimum width of two feet and eight inches.
(c) At least one principal outside entrance/exit for the residents' use shall be at grade level or accessible by ramp with a one inch rise for each 12 inches of length of the ramp. For the purposes of this Rule, a principal outside entrance/exit is one that is most often used by residents for vehicular access. If the facility has a resident that must have physical assistance with evacuation, the facility shall have two outside entrances/exits at grade level or accessible by a ramp.
(d) All outside entrance/exit door locks shall be operable by a single hand motion from the inside at all times without keys, tools, or special knowledge. Existing deadbolts and turn buttons on the inside of outside entrances/exit doors, including screen and storm doors, shall be removed or disabled.
(e) All outside entrances/exits shall be free of all obstructions or impediments to allow for full instant use in case of fire or other emergency.
(f) All steps, porches, stoops, and ramps shall have handrails and guards. Handrails shall be on both sides of steps and ramps, including sides bordered by the facility wall. Handrails shall extend the full length of steps and ramps. Guards shall be on open sides of steps, porches, stoops, and ramps. For the purposes of this Rule, "guards" are rails or barriers located at or near the open sides of elevated walking surfaces that minimizes the possibility of a fall from a walking surface to an adjacent change in elevation.
(g) In facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibiting wandering behavior, all outside entrance/exit doors shall have a continuously sounding device that is activated when the door is opened. The sound shall be audible throughout the facility. If a central system of remote sounding devices is provided, the control panel for the system shall be powered by the facility's electrical system, and be located in an area accessible to staff. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 1987; July 1, 1984; April 1, 1984;
Recodified from 10A NCAC 13G .0311 Eff. July 1, 2005;

Readopted Eff. April 1, 2025.

10A NCAC 13G .0313 LAUNDRY ROOM

(a) Laundry equipment shall be inside family care homes. For the purpose of this Rule, "laundry equipment" means at least one residential washing machine and at least one residential dryer.

(b) Laundry equipment shall be in a dedicated room or enclosure, and shall be located out of living rooms, dining rooms, dining areas, bathrooms, and bedrooms.

(c) Laundry equipment shall be on the same floor level as required residents' facilities.

(d) Laundry equipment shall be accessible to all residents, and shall be maintained operable.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 1984;
Recodified from 10A NCAC 13G .0312 Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019;
Amended Eff. April 1, 2025.

10A NCAC 13G .0314 FLOORS

(a) All floors in a family care home shall be of smooth, non-skid material and so constructed as to be easily cleanable.

(b) Scatter or throw rugs shall not be used.

(c) All floors shall be kept in good repair.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 1984;
Recodified from 10A NCAC 13G .0313 Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .0315 HOUSEKEEPING AND FURNISHINGS

(a) A family care home shall:

(1) have walls, ceilings, and floors or floor coverings that are clean, safe, and functional;
(2) have no persistent and recurring odors that are considered by the residents to be unpleasant;
(3) have furniture that is clean, safe, and functional;
(4) have a North Carolina Department of Health and Human Services, Division of Public Health, Environmental Health Section approved sanitation classification at all times, pursuant to the "Rules Governing the Sanitation of Residential Care Facilities", 15A NCAC 18A .1600, which is incorporated by reference including all subsequent amendments and can be accessed electronically free of charge at http://ehs.dph.ncddhs.gov/rules.htm;
(5) be maintained in an uncluttered, clean, and orderly manner, free of all obstructions and hazards;
(6) have a supply available in the facility at all times of bath soap, clean towels, washcloths, sheets, pillowcases, blankets, and additional covers such as a bedspread, comforter, or quilt for each resident to use;
(7) make available the following items as needed at no additional charge to the personal funds of recipients of State-County Special Assistance:
    (A) protective mattress covers, and clean, absorbent, soft, and smooth mattress pads;
    (B) bedpans and urinals; and
    (C) bedside commodes, walkers, and wheelchairs.
(8) have one television and one radio in good working order;
(9) have curtains, draperies, or blinds at windows in resident use areas to provide for resident privacy;
(10) have recreational equipment, supplies for games, books, magazines, and a weekly newspaper available for residents;

(11) have a clock that has numbers at least 1½ inches tall in the living room, the dining room, or dining area; and
(12) have at least one telephone that does not require electricity or cellular service to operate.

(b) Each bedroom shall have the following furnishings in good repair and clean for each resident:
(1) A bed equipped with a box spring and mattress or a bed frame with solid link springs with a foam mattress or a mattress designed to prevent sagging. A hospital bed equipped with all accessories required for use shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the facility. Each bed is to have the following:
(A) at least one pillow with a clean pillow case;
(B) a clean top and bottom sheet on the bed, with bed changed at least once a week and when soiled; and
(C) a clean bedspread and other clean coverings as needed.
(2) a bedside type table;
(3) chest of drawers or bureau when not provided as built-ins, or a double chest of drawers or double dresser for two residents;
(4) a wall or dresser mirror that may be used by each resident in each bedroom;
(5) a minimum of one chair that is comfortable as preferred by the resident, which may include a rocking or straight chair, with or without arms, that is high enough for the resident to easily rise without discomfort;
(6) additional chairs available, as needed, for use by visitors;
(7) individual clean towel, wash cloth, and towel bar within bedroom or adjoining bathroom; and
(8) a light overhead of bed with a switch that may be reached by a person lying on the bed; or a lamp. The light shall provide a minimum of 30 foot-candle power of illumination for reading.

(c) The living room shall have living room furnishings that are in good working order and provide comfort as preferred by residents with coverings that are easily cleanable.

(d) The dining room shall have the following furnishings:
(1) tables and chairs to seat all residents eating in the dining room; and
(2) chairs that are sturdy, non-folding, without rollers unless retractable or on front legs only, and designed to minimize tilting.

(e) Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; September 1, 1987; April 1, 1987; April 1, 1984;
Recodified from 10A NCAC 13G .0314 Eff. July 1, 2005;
Readopted Eff. April 1, 2025.

10A NCAC 13G .0316 FIRE SAFETY AND EMERGENCY PREPAREDNESS PLAN

(a) Fire extinguishers shall be provided which meet these minimum requirements in a family care home:
(1) one five pound or larger (net charge) "A-B-C" type located in an area that can be accessed by staff and not stored in rooms with lockable doors or the kitchen;
(2) one five pound or larger "A-B-C" or CO/2 type located in the kitchen; and
(3) any other location as determined by the local fire code enforcement official.

(b) The facility shall be provided with smoke detectors in locations as required by the North Carolina State Building Code: Residential Code. Additionally, facilities governed by the North Carolina State Building Code: Building Code, Licensed Residential Care Facilities Section shall be provided with smoke detectors in locations as required by that Section. All smoke detectors in the facility shall be hard-wired, interconnected, and provided with battery backup.

(c) Underwriters Laboratories, Incorporated (U.L.) listed heat detectors shall be installed in all attic spaces and in the basement of the facility. Heat detectors shall be hard-wired, interconnected, and connected to a dedicated sounding device located inside the living area of the facility. Heat detectors shall be of the rate of rise type and be provided with battery backup.

(d) The facility shall meet all fire safety requirements required by city ordinances or county building inspectors.

(e) The facility shall have a written fire evacuation plan. For the purpose of this Rule, a written fire evacuation plan is a written document that details the procedures and steps that facility occupants shall follow in a fire or other emergency to ensure safe evacuation while minimizing the risk of injury or loss of life. The written fire evacuation plan shall include a diagram of the facility floor plan which clearly marks all emergency egress and escape routes from the facility. The plan shall have the approval of the local fire code enforcement official. The approved diagram shall be legible and be posted on every floor of the facility in a location visible to staff, residents, and visitors. The fire evacuation plan and diagram shall be reviewed with each resident upon admission and shall be included in the orientation for all new staff.

(f) There shall be at least four unannounced fire drills of the fire evacuation plan every year on each shift. For the purpose of this Rule, a fire drill is the method of practicing how occupants of the facility shall evacuate in the event of a fire or other emergency. Documentation of the fire drills shall be maintained by the administrator or their designee in the facility and be made available upon request to the Division of Health Service Regulation, county department of social services, and the local fire code enforcement official. The documentation shall include the date and time of the fire drill, the shift, the names of staff members present, and a short description of drill.

(g) Each facility shall develop and implement an emergency preparedness plan to ensure resident health and safety and continuity of care and services during an emergency. The emergency preparedness plan shall include the following:

(1) Procedures to address the following threats and hazards that may create an emergency for the facility:
  - (A) weather events including hurricanes, tornadoes, ice storms, and extreme heat or cold;
  - (B) fires;
  - (C) utility failures, to include power, water, and gas;
  - (D) equipment failures, to include fire alarm, automatic sprinkler systems, HVAC systems;
  - (E) interruptions in communication including phone service and the internet;
  - (F) unforeseen widespread communicable public health and emerging infectious diseases;
  - (G) intruders and active assailants; and
  - (H) other potential threats to the health and safety of residents as identified by the facility or the local emergency management agency.

(2) The procedures outlined in Subparagraph (g)(1) of this Rule shall address the following:
  - (A) provisions for the care of all residents in the facility before, during, and after an emergency such as required emergency supplies including water, food, resident care items, medical supplies, medical records, medications, medication records, emergency power, and emergency equipment;
  - (B) provisions for the care of all residents when evacuated from the facility during an emergency, such as evacuation procedures, procedures for the identification of residents, evacuation transportation arrangements, and sheltering options that are safe and suitable for the resident population served;
  - (C) identification of residents with Alzheimer's disease and related dementias, residents with mobility limitations, and any other residents who may have specialized needs such as dialysis, oxygen, tracheostomy, and gastrostomy feeding tubes, special medical equipment, or accommodations either at the facility or in case of evacuation;
  - (D) strategies for staffing to meet the needs of the residents during an emergency and for addressing potential staffing issues;
  - (E) Procedures for coordinating and communicating with the local emergency management agency and local law enforcement;

(3) The emergency preparedness plan shall include contact information for State and local resources for emergency response, local law enforcement, facility staff, residents and responsible parties, vendors, contractors, utility companies, and local building officials such as the fire marshal and local health department.

(h) The facility shall maintain documentation that the emergency preparedness plan has written approval of or documentation that the plan has been submitted to the local emergency management agency and the local agency designated to coordinate and plan for the provision of access to functional needs support services in shelters during disasters.

(i) The facility's emergency preparedness plan shall be reviewed at least annually and updated as needed by the administrator and shall be submitted to the local emergency management agency and the local agency designated to coordinate and plan for the provision of access to functional needs support services in shelters during disasters. Any

changes to the plan shall be submitted to the local emergency management agency and the local agency designated to coordinate and plan for the provision of access to functional needs support services in shelters during disasters within 60 days of the change. For the purpose of this Rule, correction of grammatical or spelling errors do not constitute a change. Documentation of submissions shall be maintained at the facility and made available for review upon request to the Division of Health Service Regulation and county department of social services.
(j) The emergency preparedness plan outlined in Paragraph (g) of this Rule shall be maintained in the facility and be accessible to staff working in the facility.
(k) Newly licensed facilities and facilities that have changed ownership shall submit an emergency preparedness plan to the local emergency management agency and the local agency designated to coordinate and plan for the provision of access to functional needs support services in shelters during disasters within 30 days after obtaining the new license. Documentation of submissions shall be maintained at the facility and made available for review upon request to the Division of Health Service Regulation and county department of social services.
(l) The facility's emergency preparedness plan shall be made available upon request to the Division of Health Service Regulation, county department of social services, and emergency management officials.
(m) The administrator shall ensure staff are trained on their roles and responsibilities related to emergencies in accordance with the facility's emergency preparedness plan as outlined in Paragraph (g) of this Rule. Staff shall be trained upon employment and annually in accordance with Rule .1211 of this Subchapter.
(n) The facility shall conduct at least one drill per year to test the facility's emergency preparedness plan. The drill may be conducted as a tabletop exercise. For the purposes of this Rule, "tabletop exercise" means a discussion-based session led by the administrator and includes other facility staff as designated by the administrator, that reviews a potential emergency scenario and the roles and responsibilities of staff, based on the facility's emergency preparedness plan and procedures. The facility shall maintain documentation of the annual drill which shall be made available upon request to the Division of Health Service Regulation, county department of social services, and emergency management officials.
(o) If the facility evacuates residents for any reason, the administrator or their designee shall report the evacuation to the local emergency management agency, the local county department of social services, and the Division of Health Service Regulation Adult Care Licensure Section within four hours or as soon as practicable of the decision to evacuate, and shall notify the agencies within four hours of the return of residents to the facility.
(p) Any damage to the facility or building systems that disrupts the normal care and services provided to residents shall be reported to the Division of Health Service Regulation Construction Section within four hours or as soon as practicable of the incidence occurring.
(q) If a facility is ordered to evacuate residents by the local emergency management or public health official due to an emergency, the facility shall not re-occupy the building until local building or public health officials have given approval to do so.
(r) In accordance with G.S. 131D-7, if a facility intends to shelter residents from an evacuating adult care home or desires to temporarily increase the facility's licensed bed capacity, the facility shall request a waiver from the Division of Health Service Regulation prior to accepting the additional residents into the facility or as soon as practicable but no later than 48 hours after the facility has accepted the residents for sheltering. The waiver request form can be found on the Division of Health Service Regulation Adult Care Licensure Section website at https://info.ncdhhs.gov/dhsr/acls/acforms.html#resident.
(s) If a facility evacuates residents to a public emergency shelter, the facility remains responsible for the care, supervision, and safety of each resident, including providing required staffing and supplies in accordance with the Rules of this Subchapter. Evacuation to a public emergency shelter shall be a last resort, and the decision shall be made in consultation with the local emergency management agency, or the local agency designated to coordinate and plan for the provision of access to functional needs support services in shelters during disasters. If a facility evacuates residents to a public emergency shelter, the facility shall notify the Division of Health Service Regulation Adult Care Licensure Section and the county department of social services within four hours of the decision to evacuate or as soon as practicable.
(t) Where a fire alarm or automatic sprinkler system is out of service, the facility shall immediately notify the fire department, the fire marshal, and the Division of Health Service Regulation Construction Section and, where required by the fire marshal, a fire watch shall be conducted until the impaired system has been returned to service as approved by the fire marshal. The facility will adhere to the instructions provided by the fire marshal related to the duties of staff performing the fire watch. The facility will maintain documentation of fire watch activities which shall be made available upon request to the DHSR Construction Section and fire marshal. The facility shall notify the DHSR Construction Section when the facility is no longer conducting a fire watch as directed by the fire marshal.

(u) Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities.

History Note: Authority G.S. 131D-2.16; 131D-7; 143B-165;
Eff. January 1, 1977;
Amended Eff. April 22, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; July 1, 1990; April 1, 1987; April 1, 1984;
Recodified from 10A NCAC 13G .0315 Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019;
Amended Eff. June 1, 2025.

10A NCAC 13G .0317 BUILDING SERVICE EQUIPMENT

(a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition.
(b) Built-in electric heaters, if used, shall be installed or protected so as to avoid burn hazards to residents and room furnishings. Unvented fuel burning room heaters and portable electric heaters are prohibited.
(c) The facility shall have heating and cooling systems such that environmental temperature controls are capable of maintaining temperatures in the home at 75 degrees F minimum in the heating season, and not exceed 80 degrees F during the non-heating season.
(d) Hot water shall be supplied to the kitchen, bathrooms, and laundry. The hot water temperature shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F at all fixtures used by or accessible to residents. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities.
(e) All resident areas shall be well lighted for the safety and comfort of the residents. The minimum lighting required is:

(1) 30 foot-candles for reading; and
(2) 10 foot-candles for general lighting.

(f) Where there is live-in staff in a family care home, a hard-wired, electrically operated call system meeting the following requirements shall be provided:

(1) the call system shall connect residents' bedrooms to the live-in staff bedroom;
(2) when activated, the resident call shall activate a visual and audible signal in the live-in staff bedroom;
(3) a resident call system activator shall be in residents' bedrooms at the resident's bed;
(4) the resident call system activator shall be within reach of a resident lying on the bed; and
(5) the resident call system activator shall be such that it can be activated with a single action and remain on until deactivated by staff at point of origin.

(g) Fireplaces, fireplace inserts, and wood stoves shall be designed and installed so as to avoid a burn hazard to residents. Fireplace inserts and wood stoves must be U.L. listed.
(h) Gas logs may be installed if they are of the vented type, installed according to the manufacturers' installation instructions, approved through the local building department, and protected by a guard or screen to prevent residents and furnishings from burns.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1987; April 1, 1984; July 1, 1982;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2005; July 1, 2000;
Recodified from 10A NCAC 13G .0316 Eff. July 1, 2005;
Readopted Eff. April 1, 2025.

10A NCAC 13G .0318 OUTSIDE PREMISES

(a) The outside grounds of new and existing family care homes shall be maintained in a clean and safe condition. For the purpose of this Rule, "clean and safe condition" means free from debris, trash, uneven surfaces, and similar

conditions as not to attract rodents and vermin, and provide for safe movement throughout facility grounds. Creeks, ditches, ponds, pools, and other similar areas shall have safety protection. For the purpose of this Rule, "safety protection" means preventive measures, such as barriers, to block access to such areas.
(b) If the facility has a fence around the premises, the fence shall not prevent residents from exiting or entering freely, or have sharp edges, rusting posts, or other similar conditions that may cause injury.
(c) Outdoor stairways and ramps shall be illuminated by no less than five foot-candles of light at grade level.
(d) Notwithstanding the requirements of Rule .0301 of this Section, the requirements of Paragraphs (a) and (b) of this Rule shall apply to new and existing facilities.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. April 1, 1984;
Amended Eff. July 1, 2005; July 1, 1990;
Recodified from 10A NCAC 13G .0317 Eff. July 1, 2005;
Readopted Eff. April 1, 2025.

SECTION .0400 – STAFF QUALIFICATIONS

10A NCAC 13G .0401 QUALIFICATIONS OF ADMINISTRATOR

History Note: *Authority G.S. 131D-2; 143B-153;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; September 1, 1987; April 1, 1987; April 1, 1984;
ARRC Objection Lodged January 18, 1991;
Amended Eff. August 1, 1991;
Repealed Eff. April 1, 2017.

10A NCAC 13G .0402 QUALIFICATIONS OF SUPERVISOR-IN-CHARGE

The supervisor-in-charge, who is responsible to the administrator for carrying out the program in a family care home in the absence of the administrator, shall meet the following requirements:

(1) be 21 years or older, if employed on or after the effective date of this Rule;
(2) the supervisor-in-charge, employed on or after August 1, 1991, shall be a high school graduate or certified under the GED Program or passed the alternative examination established by the Department of Health and Human Services prior to the effective date of this Rule; and
(3) earn 12 hours a year of continuing education credits related to the management of adult care homes and care of aged and disabled persons.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
ARRC Objection June 16, 1988;
Amended Eff. July 1, 1990; December 1, 1988; April 1, 1987; January 1, 1985;
ARRC Objection Lodged January 18, 1991;
Amended Eff. August 1, 1991;
Readopted Eff. July 1, 2021.

10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF

(a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement.
(b) Medication aides and their direct supervisors, except persons authorized by state occupational licensure laws to administer medications, shall complete six hours of continuing education annually related to medication administration.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 131D-4.5B; 143B-165;*

Temporary Adoption Eff. January 1, 2000; December 1, 1999;
Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005;
Readopted Eff. July 1, 2021.

10A NCAC 13G .0404 QUALIFICATIONS OF ACTIVITY DIRECTOR

Adult care homes shall have an activity director who meets the following qualifications:

(1) The activity director hired after September 30, 2022 shall meet a minimum educational requirement by being a high school graduate or certified under the GED Program.

(2) The activity director hired after September 30, 2022 shall have complete, within nine months of employment or assignment to this position, the basic activity course for assisted living activity directors offered by community colleges or a comparable activity course as determined by the Department based on instructional hours and content. An activity director shall be exempt from the required basic activity course if one or more of the following applies:

(a) be a licensed recreational therapist or be eligible for certification as a therapeutic recreation specialist as defined by the North Carolina Recreational Therapy Licensure Act in accordance with G.S. 90C;

(b) have two years of experience working in programming for an adult recreation or activities program within the last five years, one year of which was full-time in an activities program for patients or residents in a health care or long term care setting;

(c) be a licensed occupational therapist or licensed occupational therapy assistant in accordance with G.S. 90, Article 18D; or

(d) be certified as an Activity Professional by the National Certification Council for Activity Professionals; or

(e) the required basic activity course was completed prior to September 1, 2024.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. April 1, 1984;
Amended Eff. July 1, 1990; April 1, 1987; January 1, 1985;
ARRC Objection Lodged March 18, 1991;
Amended Eff. August 1, 1991;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005;
Readopted Eff. October 1, 2022;
Amended Eff. September 1, 2024.

10A NCAC 13G .0405 TEST FOR TUBERCULOSIS

(a) Upon employment or moving into a family care home, the administrator, all other staff, and any persons living in the family care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments.

(b) There shall be documentation on file in the family care home that the administrator, all other staff, and any persons living in the family care home are free of tuberculosis disease.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. January 1, 1977;
Amended Eff. October 1, 1977; April 22, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. December 1, 1993; April 1, 1984;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004;
Readopted Eff. July 1, 2021.

10A NCAC 13G .0406 OTHER STAFF QUALIFICATIONS

(a) Each staff person of a family care home shall:

(1) have a job description that reflects the position's duties, and responsibilities and is signed by the administrator and the employee;
(2) be able to implement all of the family care home's accident, fire safety, and emergency procedures for the protection of the residents;
(3) be informed of the confidential nature of resident information and shall protect and preserve the information from unauthorized use and disclosure, in accordance with G.S. 131D-21(6), and G.S. 131D-21.1;
(4) not hinder or interfere with the exercise of the rights guaranteed under the Declaration of Residents' Rights in G.S. 131D-21;
(5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;
(6) have documented annual immunization against influenza virus according to G.S. 131D-9, and exceptions as provided in the law shall be documented in the staff person's personnel record;
(7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file;
(8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file;
(9) maintain a current driver's license if responsible for transportation of residents; and
(10) be willing to cooperate with state and local inspectors when determining and maintaining compliance with the rules of this Subchapter.

(b) At all times, there shall be at least one staff person in the facility in charge of resident care who shall be 18 years or older.

(c) If licensed practical nurses are employed by the facility and practicing in their licensed capacity as governed by the North Carolina Board of Nursing, there shall be a registered nurse available in accordance with the rules set forth in 21 NCAC 36 .0224 and 21 NCAC 36 .0225, which are hereby incorporated by reference including subsequent amendments.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0407 FISCAL QUALIFICATIONS

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. July 1, 1990;
Expired Eff. March 1, 2019 pursuant to G.S. 150B-21.3A.

SECTION .0500 – STAFF ORIENTATION, TRAINING, COMPETENCY AND CONTINUING EDUCATION

10A NCAC 13G .0501 PERSONAL CARE TRAINING AND COMPETENCY

(a) The facility shall assure that staff who provide or directly supervise staff who provide personal care to residents complete an 80-hour personal care training and competency evaluation program established by the Department. For the purpose of this Rule, "directly supervise" means being on duty in the facility to oversee or direct the performance of staff duties. A copy of the 80-hour training and competency evaluation program is available online at https://info.ncdhhs.gov/dhsr/acls/training/index.html#80hr, at no cost. The 80-hour personal care training and competency evaluation program curriculum shall include:
(1) observation and documentation skills;
(2) basic nursing skills, including special health-related tasks;
(3) activities of daily living and personal care skills;

(4) cognitive, behavioral, and social care;
(5) basic restorative services; and
(6) residents' rights as established by G.S. 131D-21.

(b) The facility shall assure that training specified in Paragraph (a) of this Rule is completed within six months after hiring for staff hired after September 30, 2022. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review by the Division of Health Service Regulation and the county department of social services.

(c) The facility shall assure that staff who perform or directly supervise staff who perform personal care receive training and supervision for the performance of individual job assignments prior to meeting the training and competency requirements of this Rule. Documentation of training shall be maintained in the facility and available for review by the Division of Health Service Regulation and the county department of social services.

(d) The Department shall exempt staff from the 80-hour training and competency evaluation program who are:
(1) licensed health professionals;
(2) listed on the Nurse Aide Registry; or
(3) documented as having completed one of the following previously approved training programs:
(A) a 20-hour or 75-hour training and competency evaluation program prior to July 1, 2000; or
(B) a 25-hour or 80-hour training and competency evaluation program from July 1, 2000 through September 30, 2017.

History Note: Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 143B-165;
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0502 PERSONAL CARE TRAINING AND COMPETENCY PROGRAM APPROVAL

History Note: Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 143B-165;
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Repealed Eff. October 1, 2022.

10A NCAC 13G .0503 MEDICATION ADMINISTRATION COMPETENCY EVALUATION

(a) The competency evaluation for medication administration shall consist of a written examination and a clinical skills validation to determine competency in the following areas:
(1) medical abbreviations and terminology;
(2) transcription of medication orders;
(3) obtaining and documenting vital signs;
(4) procedures and tasks involved with the preparation and administration of oral (including liquid, sublingual and inhaler), topical (including transdermal), ophthalmic, otic, and nasal medications;
(5) infection control procedures;
(6) documentation of medication administration;
(7) monitoring for reactions to medications and procedures to follow when there appears to be a change in the resident's condition or health status based on those reactions;
(8) medication storage and disposition;
(9) rules pertaining to medication administration in adult care facilities; and
(10) the facility's medication administration policy and procedures.

(b) An individual shall score at least 90% on the written examination which shall be a standardized examination established by the Department.

(c) Verification of an individual's completion of the written examination and results can be obtained at no charge on the North Carolina Adult Care Medication Aide Testing website at https://mats.ncdhhs.gov/test-result.

(d) The clinical skills validation portion of the competency evaluation shall be conducted by a registered nurse or a licensed pharmacist and who has a current unencumbered license in North Carolina. The registered nurse or licensed pharmacist shall conduct a clinical skills validation for each medication administration task or skill that will be performed in the facility. Competency validation by a registered nurse is required for unlicensed staff who perform any of the personal care tasks related to medication administration listed in Subparagraphs (a)(4), (a)(7), (a)(11), (a)(14), and (a)(15) as specified in Rule .0903 of this Subchapter.
(e) The Medication Administration Skills Validation Form shall be used to document successful completion of the clinical skills validation portion of the competency evaluation for those medication administration tasks to be performed in the facility employing the medication aide. The form requires the following:

(1) name of the staff and adult care home;
(2) satisfactory completion date of demonstrated competency of task or skill with the instructor's initials or signature;
(3) if staff needs more training on skills or tasks, it should be noted with the instructor's signature; and
(4) staff and instructor signatures and date after completion of tasks.

Copies of this form and instructions for its use may be obtained at no cost on the Adult Care Licensure website, https://info.ncdhhs.gov/dhsr/acls/pdf/medchklst.pdf. The completed form shall be maintained and available for review in the facility and is not transferable from one facility to another.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. January 1, 2000; December 1, 1999;
Eff. July 1, 2000;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0504 COMPETENCY EVALUATION AND VALIDATION FOR LICENSED HEALTH PROFESSIONAL SUPPORT TASKS

(a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task.
(b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident.
(c) Evaluation and validation of competency shall be performed by the following licensed health professionals in accordance with his or her North Carolina occupational licensing laws:

(1) A registered nurse shall validate the competency of staff who perform any of the personal care tasks specified in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter;
(2) In lieu of a registered nurse, a licensed respiratory care practitioner may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(6), (11), (16), (18), (19), and (21) of Rule .0903 of this Subchapter;
(3) In lieu of a registered nurse, a licensed pharmacist may validate the competency of staff who perform the personal care tasks specified in Subparagraph (a)(8) and (11) of Rule .0903 of this Subchapter. An immunizing pharmacist may validate the competency of staff who perform the personal care task specified in Subparagraph (a)(15) of Rule .0903 of this Subchapter; and
(4) In lieu of a registered nurse, an occupational therapist or physical therapist may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(17) and (a)(22) through (a)(27) of Rule .0903 of this Subchapter.

(d) If a physician certifies that care can be provided to a resident in a family care home on a temporary basis in accordance with G.S. 131D-2.2(a), the facility shall ensure that the staff performing the care task(s) authorized by the physician are competent to perform the task(s) in accordance with Paragraphs (b) and (c) of this Rule. For the purpose of this Rule, "temporary basis" means a length of time as determined by the resident's physician to meet the care needs of the resident and prevent the resident's relocation from the family care home.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. September 1, 2003;
Eff. July 1, 2004;
Readopted Eff. October 1, 2022;

Amended Eff. October 1, 2023.

10A NCAC 13G .0505 TRAINING ON CARE OF DIABETIC RESIDENTS

A family care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows:

(1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner.
(2) Training shall include at least the following:
  (a) basic facts about diabetes and care involved in the management of diabetes;
  (b) insulin action;
  (c) insulin storage;
  (d) mixing, measuring and injection techniques for insulin administration;
  (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms;
  (f) blood glucose monitoring; universal precautions; appropriate administration times; and
  (g) sliding scale insulin administration.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. September 1, 2003;
Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .0506 TRAINING ON PHYSICAL RESTRAINTS

(a) A family care home shall assure that all staff responsible for caring for residents with medical symptoms that warrant restraints are trained on the use of alternatives to physical restraint use and on the care of residents who are physically restrained.

(b) Training shall be provided by a registered nurse and shall include the following:

(1) alternatives to physical restraints;
(2) types of physical restraints;
(3) medical symptoms that warrant physical restraint;
(4) negative outcomes from using physical restraints;
(5) correct application of physical restraints;
(6) monitoring and caring for residents who are restrained; and
(7) the process of reducing restraint time by using alternatives.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. September 1, 2003;
Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .0507 TRAINING ON CARDIO-PULMONARY RESUSCITATION

Each family care home shall have one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute and Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. September 1, 2003;
Eff. July 1, 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0508 ASSESSMENT TRAINING

The person or persons designated by the administrator to perform resident assessments as required by Rule .0801 of this Subchapter shall read the Resident Assessment Self-Instructional Manual for Adult Care Homes established by the Department and certify completion by signature on the last page of the manual before performing the required resident assessments. Registered nurses are exempt from this requirement. The Resident Assessment Self-Instructional Manual for Adult Care Homes is herein incorporated by reference including subsequent amendments and editions and is available on the Adult Care Licensure website, https://info.ncdhhs.gov/dhsr/acls/pdf/assessmentmanual.pdf, at no cost.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. September 1, 2003;
Eff. June 1, 2004;
Amended Eff. April 1, 2022;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0509 FOOD SERVICE ORIENTATION

Family care home staff who prepare and serve food shall complete a food service orientation training that provides an overview of food service in adult care homes, including the preparation of therapeutic diets, established by the Department or an equivalent that contains at least the same information as required in the training approved by the Department within 30 days of hire. The food service orientation training is available at https://info.ncdhhs.gov/dhsr/acls/pdf/foodsrvman.pdf, at no cost.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, 2005;
Readopted Eff. January 1, 2022.

10A NCAC 13G .0510 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13G .0511 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13G .0512 DOCUMENTATION OF TRAINING AND COMPETENCY VALIDATION

A family care home shall maintain documentation of the training and competency validation of staff required by the rules of this Section in the facility and available for review.

History Note: Authority G.S. 131D-2.16; 143B-165;
Temporary Amendment Eff. September 1, 2003;
Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

SECTION .0600 – STAFFING OF THE FACILITY

10A NCAC 13G .0601 MANAGEMENT AND OTHER STAFF

(a) A family care home administrator who is approved in accordance with Rule .1501 of this Subchapter shall be responsible for the total operation and management of the facility to assure that all care and services are provided to maintain the health, safety, and welfare of the residents in accordance with all applicable local, state, and federal regulations and codes. The administrator shall also be responsible to the Division of Health Service Regulation and the county department of social services for complying with the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the facility and for meeting and maintaining the rules of this Subchapter. The term "administrator" also refers to co-administrator where it is used in this Subchapter.

(b) The administrator shall have knowledge of and shall ensure the following:

(1) the investigation and reporting of any allegations of resident abuse, neglect, and exploitation as specified in Rule .1213(d) of this Subchapter;

(2) the investigation and reporting of any suspicion of or allegations of drug diversion as specified in Rule .1008 of this Subchapter;
(3) the reporting of any incidents of resident elopement or when a resident is missing from the facility as required in Rule .1213(e)(2) and Rule .0906(f)(4) of this Subchapter; and
(4) the investigation and reporting of any incident or accident resulting in the hospitalization or death of a resident as specified in Rule .1209 and Rule .1213 of this Subchapter.

(c) The administrator shall be made aware when the facility is unable to meet the staffing requirements of this Section.
(d) The administrator shall be made aware any time the facility seeks the assistance of the local law enforcement authority.
(e) At all times the administrator or supervisor-in-charge shall be in the facility or within 500 feet of the facility with a means of two-way telecommunication. The administrator or supervisor-in-charge is directly responsible for assuring that all required duties are carried out in the facility and for assuring that at no time is a resident left alone in the facility without a staff member.
(f) When the administrator or supervisor-in-charge are not in the facility or within 500 feet of the facility, a staff person who meets the staff qualification requirements of this Subchapter shall be on duty in the facility. The staff person shall be on duty in the facility no more than eight hours per 24 hours and no more than 24 hours total per week.
(g) Additional staff shall be employed as needed for housekeeping and the supervision and care of the residents in accordance with the rules of this Subchapter.
(h) The facility shall post daily staffing information in a location accessible to residents and visitors in accordance with G.S.131D-4.3(a)(5). The information shall include:
(1) the name and contact information of the administrator and supervisor in charge;
(2) the number of required supervisors on each shift; and
(3) the number of aides required on each shift.

History Note: Authority G.S. 131D-2.16; 131D-25; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; July 1, 1990; April 1, 1987; April 1, 1984; June 26, 1980;
Readopted Eff. September 1, 2024.

10A NCAC 13G .0602 THE CO-ADMINISTRATOR

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Expired Eff. March 1, 2019 pursuant to G.S. 150B-21.3A.

SECTION .0700 - ADMISSION AND DISCHARGE

10A NCAC 13G .0701 ADMISSION OF RESIDENTS

(a) Any adult (18 years of age or over) who, because of a temporary or chronic physical condition or mental disability, needs a substitute home may be admitted when, in the opinion of the resident, physician, family or social worker, and the administrator the services and accommodations of the home will meet his particular needs.
(b) Exceptions. People are not to be admitted:
(1) for treatment of mental illness, or alcohol or drug abuse;
(2) for maternity care;
(3) for professional nursing care under continuous medical supervision;
(4) for lodging, when the personal assistance and supervision offered for the aged and disabled are not needed; or
(5) who pose a direct threat to the health or safety of others.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;

Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; January 1, 1989;
Temporary amendment Eff. October 14, 1992 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Amended Eff. February 1, 1993; April 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .0702 TUBERCULOSIS TEST AND MEDICAL EXAMINATION, AND IMMUNIZATIONS

(a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions.

(b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the home and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident.

(c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission.

(d) In the case of an unplanned, emergency admission, the medical examination of the resident shall be conducted within 72 hours after admission. Prior to an emergency admission, the facility shall obtain current medication and treatment orders from a licensed physician or physician extender.

(e) The result of the medical examination required in Paragraph (b) of this Rule shall be documented on the North Carolina Medicaid Adult Care Home FL-2 form which is available at no cost on the Department's Medicaid website at https://medicaid.ncdhhs.gov/media/6549/open. The Adult Care Home FL-2 shall be signed and dated by the physician or physician extender completing the medical examination. The medical examination shall include the following:

(1) resident's identification information, including the resident's name, date of birth, sex, admission date, county and Medicaid number, current facility and address, physician's name and address, a relative's name and address, current level of care, and recommended level of care;

(2) resident's admitting diagnoses, including primary and secondary diagnoses and dates of onset;

(3) resident's current medical information, including orientation, behaviors, personal care assistance needs, frequency of physician visits, ambulatory status, functional limitations, information related to activities and social needs, neurological status, bowel and bladder functioning status, manner of communication of needs, skin condition, respiratory status, and nutritional status including orders for therapeutic diets;

(4) special care factors, including physician orders for blood pressure, diabetic urine testing, physical therapy, range of motion exercises, a bowel and bladder program, a restorative feeding program, speech therapy, and restraints;

(5) resident's medications, including the name, strength, dosage, frequency and route of administration of each medication;

(6) results of x-rays or laboratory tests determined by the physician or physician extender to be necessary information related to the resident's care needs; and

(7) additional information as determined by the physician or physician extender to be necessary for the care of the resident.

(f) If the information on the Adult Care Home FL-2 is not clear or is insufficient, or information provided to the facility related to the resident's condition or medications after the completion of the medical examination conflicts with the information provided on the Adult Care Home FL-2, the facility shall contact the physician or physician extender for clarification in order to determine if the facility can meet the individual's needs.

(g) The results of the medical examination shall be maintained in the resident's record in accordance with Rule .1201 of this Subchapter. Discharge medication orders shall be clarified in accordance with Rule .1002(a) of this Subchapter.

(h) Upon a resident's return to the facility from a hospitalization, the facility shall obtain and review the hospital discharge summary or discharge instructions, including any discharge medication orders. If the facility identifies discrepancies between the discharge orders and current orders at the facility, the facility shall clarify the discrepancies with the resident's physician or physician extender.

(i) Each resident shall be immunized against pneumococcal disease and annually against influenza virus according to G.S. 131D-9, except as otherwise indicated in law.
(j) The facility shall make arrangements for a resident to be evaluated by a licensed mental health professional, licensed physician or licensed physician extender for follow-up psychiatric care within 30 days of admission or re-admission to the facility when the resident:

(1) has been an inpatient of a psychiatric facility within 12 months prior to admission to the facility and does not have a current plan for follow-up psychiatric care; or
(2) has been hospitalized due to threatening or violent behavior, suicidal ideation or self-harm, or other psychiatric symptoms that required hospitalization within 12 months prior to admission to the facility and does not have a current plan for follow-up psychiatric care.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. December 1, 1993; July 1, 1990; April 1, 1987; April 1, 1984;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004;
Readopted Eff. June 1, 2024.

10A NCAC 13G .0703 RESIDENT REGISTER

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1987; April 1, 1984;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. April 1, 2022; July 1, 2005;
Repealed Eff. June 1, 2024.

10A NCAC 13G .0704 RESIDENT CONTRACT, INFORMATION ON FACILITY, AND RESIDENT REGISTER

(a) The administrator or supervisor-in-charge shall furnish and review with the resident or the resident's authorized representative as defined in Rule .1103 of this Subchapter information on the facility upon admission and when changes are made to that information. The facility shall involve the resident in the review of the resident contract and information on the facility unless the resident is cognitively unable to participate in the discussion. A statement indicating that this information has been received upon admission or amendment as required by this Rule shall be signed and dated by each person to whom it is given. This statement shall be retained in the resident's record in the facility. The information shall consist of the following:

(1) the resident contract to which the following applies:
  (A) the contract shall specify charges for resident services and accommodations, including the cost of different levels of service, description of levels of care and services, and any other charges or fees;
  (B) the contract shall disclose any health needs or conditions that the facility has determined it cannot meet;
  (C) the contract shall be signed and dated by the administrator or supervisor-in-charge and the resident or the resident's authorized representative and a copy given to the resident or the resident's authorized representative and a copy kept in the resident's record;
  (D) the resident or the resident's authorized representative shall be given a written 30-day notice prior to any change in charges for resident services and accommodations, including the cost of different levels of service, description of level of care and services, and any other charges or fees, and be provided an amended copy of the contract for review and confirmation of receipt;
  (E) gratuities in addition to the established rates shall not be accepted; and
  (F) The maximum monthly rate that may be charged to Special Assistance recipients as established by the North Carolina General Assembly;

(2) a written copy of any house rules, including facility's policies on smoking, alcohol consumption, visitation, refunds, and the requirements for discharge of residents consistent with the rules in this Subchapter and amendments disclosing any changes in the house rules. The house rules shall be in compliance with G.S. 131D-21;
(3) a copy of the Declaration of Residents' Rights as found in G.S. 131D-21;
(4) a copy of the facility's grievance procedures that shall indicate how the resident is to present complaints and make suggestions as to the facility's policies and services on behalf of self or others; and
(5) a statement as to whether the facility has signed Form DSS-1464, Statement of Assurance of Compliance with Title VI of the Civil Rights Act of 1964 for Other Agencies, Institutions, Organizations or Facilities, and which shall also indicate that if the facility does not choose to comply or is non-compliant the residents of the facility would not be able to receive State-County Special Assistance for Adults and the facility would not receive supportive services from the county department of social services.

(b) A family care home's administrator or supervisor-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register initial assessment within 72 hours of the resident's admission to the facility in accordance with G.S. 131D-2.15. The facility shall involve the resident in the completion of the Resident Register unless the resident is cognitively unable to participate. The Resident Register shall consist of the following:
(1) resident's identification information including the resident's name, date of birth, sex, admission date, medical insurance, family and emergency contacts, advanced directives, and physician's name and address;
(2) resident's current care needs including activities of daily living and services, use of assistive aids, orientation status;
(3) resident's preferences including personal habits, food preferences and allergies, community involvement, and activity interests;
(4) resident's consent and request for assistance including the release of information, personal funds management, personal lockable space, discharge information, and assistance with personal mail;
(5) name of the individual identified by the resident who is to receive a copy of the notice of discharge per G.S. 131D-4.8; and
(6) resident's consent including a signature confirming the review and receipt of information contained in the form.

The Resident Register is available on the internet website, https://info.ncdhhs.gov/dhsr/acls/pdf/resregister.pdf, at no charge. The facility may use a resident information form other than the Resident Register as long as it contains same information as the Resident Register. Information on the Resident Register shall be kept updated and maintained in the resident's record.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. April 1, 1984;
Amended Eff; July 1, 1990; April 1, 1987;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005;
Readopted Eff. June 1, 2024.

10A NCAC 13G .0705 DISCHARGE OF RESIDENTS (EFFECTIVE UNTIL MARCH 31, 2024)

(a) The discharge of a resident initiated by the facility shall be according to conditions and procedures specified in Paragraphs (a) through (g) of this Rule. The discharge of a resident initiated by the facility involves the termination of residency by the facility resulting in the resident's move to another location and the facility not holding the bed for the resident based on the facility's bed hold policy.

(b) The discharge of a resident shall be based on one of the following reasons:
(1) the discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility as documented by the resident's physician, physician assistant or nurse practitioner;
(2) the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility as documented by the resident's physician, physician assistant or nurse practitioner;
(3) the safety of other individuals in the facility is endangered;

(4) the health of other individuals in the facility is endangered as documented by a physician, physician assistant or nurse practitioner;
(5) failure to pay the costs of services and accommodations by the payment due date according to the resident contract after receiving written notice of warning of discharge for failure to pay; or
(6) the discharge is mandated under G.S. 131D-2(a1).

(c) The notices of discharge and appeal rights as required in Paragraph (e) of this Rule shall be made by the facility at least 30 days before the resident is discharged except that notices may be made as soon as practicable when:
(1) the resident's health or safety is endangered and the resident's urgent medical needs cannot be met in the facility under Subparagraph (b)(1) of this Rule; or
(2) reasons under Subparagraphs (b)(2), (b)(3), and (b)(4) of this Rule exist.

(d) The reason for discharge shall be documented in the resident's record. Documentation shall include one or more of the following as applicable to the reasons under Paragraph (b) of this Rule:
(1) documentation by physician, physician assistant or nurse practitioner as required in Paragraph (b) of this Rule;
(2) the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility's action taken to address the problem prior to pursuing discharge of the resident;
(3) written notices of warning of discharge for failure to pay the costs of services and accommodations; or
(4) the specific health need or condition of the resident that the facility determined could not be met in the facility pursuant to G.S. 131D-2(a1)(4) and as disclosed in the resident contract signed upon the resident's admission to the facility.

(e) The facility shall assure the following requirements for written notice are met before discharging a resident:
(1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from the Division of Medical Assistance, 2505 Mail Service Center, Raleigh, NC 27699-2505.
(2) A copy of the Adult Care Home Notice of Discharge with a copy of the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative on the same day the Adult Care Home Notice of Discharge is dated.
(3) Failure to use and simultaneously provide the specific forms according to Subparagraphs (e)(1) and (e)(2) of this Rule shall invalidate the discharge. Failure to use the latest version of these forms shall not invalidate the discharge unless the facility has been previously notified of a change in the forms and been provided a copy of the latest forms by the Department of Health and Human Services.
(4) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record.

(f) The facility shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by:
(1) notifying staff in the county department of social services responsible for placement services;
(2) explaining to the resident and responsible person or legal representative why the discharge is necessary;
(3) informing the resident and responsible person or legal representative about an appropriate discharge destination; and
(4) offering the following material to the caregiver with whom the resident is to be placed and providing this material as requested prior to or upon discharge of the resident:
    (A) a copy of the resident's most current FL-2;
    (B) a copy of the resident's most current assessment and care plan;
    (C) a copy of the resident's current physician orders;
    (D) a list of the resident's current medications;
    (E) the resident's current medications; and
    (F) a record of the resident's vaccinations and TB screening.

(5) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (e) of this Rule:
  (A) the regional long term care ombudsman; and
  (B) the protection and advocacy agency established under federal law for persons with disabilities.

(g) If an appeal hearing is requested:
(1) the facility shall provide to the resident or legal representative or the resident and the responsible person, and the Hearing Unit copies of all documents and records that the facility intends to use at the hearing at least five working days prior to the scheduled hearing; and
(2) the facility shall not discharge the resident before the final decision resulting from the appeal has been rendered, except in those cases of discharge specified in Paragraph (c) of this Rule.

(h) If a discharge is initiated by the resident or responsible person, the administrator may require up to a 14-day written notice from the resident or responsible person which means the resident or responsible person may be charged for the days of the required notice if notice is not given or if notice is given and the resident leaves before the end of the required notice period. Exceptions to the required notice are cases in which a delay in discharge or transfer would jeopardize the health or safety of the resident or others in the facility. The facility's requirement for a notice from the resident or responsible person shall be established in the resident contract or the house rules provided to the resident or responsible person upon admission.

(i) The discharge requirements in this Rule do not apply when a resident is transferred to an acute inpatient facility for mental or physical health evaluation or treatment and the adult care facility's bed hold policy applies based on the expected return of the resident. If the facility decides to discharge a resident who has been transferred to an acute inpatient facility and there has been no physician-documented level of care change for the resident, the discharge requirements in this Rule apply.

History Note: Authority G.S. 131D-2.1; 131D-2.16; 131D-4.8; 131D-4.5; 131D-21; 143B-165;
Temporary Adoption Eff. January 1, 2000; December 1, 1999;
Eff. April 1, 2001;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. July 1, 2004.

10A NCAC 13G .0705 DISCHARGE OF RESIDENTS (EFFECTIVE APRIL 1, 2024)

(a) The discharge of a resident initiated by the facility shall be according to conditions and procedures specified in Paragraphs (a) through (j) of this Rule. The discharge of a resident initiated by the facility involves the termination of residency by the facility resulting in the resident's move to another location and the facility not holding the bed for the resident based on the facility's bed hold policy.

(b) The discharge of a resident initiated by the facility at the direction of the administrator or their designee shall be based on one of the following reasons:
(1) the discharge is necessary to protect the welfare of the resident and the facility cannot meet the needs of the resident, as documented by the resident's physician, physician assistant, or nurse practitioner in the resident's record;
(2) the health of the resident has improved sufficiently so that the resident is no longer in need of the services provided by the facility, as documented by the resident's physician, physician assistant, or nurse practitioner in the resident's record;
(3) the safety of the resident or other individuals in the facility is endangered as determined by the facility at the direction of the administrator or their designee in consultation with the resident's physician, physician assistant, or nurse practitioner;
(4) the health of the resident or other individuals in the facility is endangered as documented by a physician, physician assistant, or nurse practitioner in the resident's record; or
(5) the resident has failed to pay the costs of services and accommodations by the payment due date according to the resident's contract after receiving written notice of warning of discharge for failure to pay.

(c) The facility administrator or their designee, shall assure the following requirements for written notice are met before discharging a resident:
(1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be completed and hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from the

Division of Health Benefits, on the internet website https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms. The Adult Care Home Notice of Discharge shall include the following:

(A) the date of notice;
(B) the date of transfer or discharge;
(C) the reason for the notice;
(D) the name of responsible person or contact person notified;
(E) the planned discharge location;
(F) the appeal rights;
(G) the contact information for the long-term care ombudsman; and
(H) the signature and date of the administrator.

(2) A copy of the completed Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative and the individual identified upon admission to receive a discharge notice on behalf of the resident on the same day the Adult Care Home Notice of Discharge is dated. For the purposes of this Rule "responsible person" means a person chosen by the resident to act on their behalf to support the resident in decision-making; access to medical, social, or other personal information of the resident; manage financial matters; or receive notifications. The Adult Care Home Hearing Request Form shall include the following:

(A) the name of the resident;
(B) the name of the facility;
(C) the date of transfer or discharge;
(D) the date of scheduled transfer or discharge;
(E) the selection of how the hearing is to be conducted;
(F) the name of the person requesting the hearing; and
(G) for the person requesting the hearing, their relationship to the resident, address, telephone number, their signature, and date of the request.

(3) Provide the following material in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to the resident and the resident's legal representative and the individual identified upon admission to receive a copy the discharge notice on behalf of the resident:

(A) a copy of the resident's most current FL-2 form required in Rule .0703 of this Subchapter;
(B) a copy of the resident's current physician's orders, including medication order;

(4) Failure to use and simultaneously provide the specific forms according to Subparagraphs (c)(1) and (c)(2) of this Rule shall invalidate the discharge.

(5) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility administrator or their designee prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record.

(d) The notices of discharge and appeal rights as required in Paragraph (c) of this Rule shall be made by the facility administrator or their designee, at least 30 days before the resident is discharged except that notices may be made as soon as practicable when:

(1) the discharge is necessary to protect the welfare of the resident and the facility cannot meet the needs of the resident under Subparagraph (b)(1) of this Rule; or
(2) reasons under Subparagraphs (b)(3) and (b)(4) of this Rule exist.

(e) The following shall be documented in the resident record and shall be made available upon request to potential discharge locations pursuant to the HIPAA Standards for Privacy of Individually Identifiable Health Information which is hereby incorporated by reference, including any amendments and subsequent editions, and can be found at no cost at https://www.federalregister.gov/documents/2002/08/14/02-20554/standards-for-privacy-of-individually-identifiable-health-information:

(1) The reason for discharge to include one or more of the following as applicable to the reasons under Paragraph (b) of this Rule:

(A) documentation by physician, physician assistant or nurse practitioner as required in Paragraph (b) of this Rule;

(B) the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility's taken to address the problem prior to pursuing discharge of the resident;

(C) written notices of warning of discharge for failure to pay the costs of services and accommodations; or

(D) the specific health need or condition of the resident that the facility determined could not be met in the facility pursuant to G.S. 131D-2.2(a)(4) and as disclosed in the resident contract signed upon the resident's admission to the facility; and

(2) any known involvement of law enforcement with the resident due to threatening behavior or violence toward self or others.

(f) The facility administrator or their designee shall document contacts with possible discharge locations and responses and make available this documentation, upon request, to the resident, legal representative, the individual identified upon admission to receive a discharge notice on behalf of the resident and the adult care home resident discharge team if convened. For the purposes of this Rule, "the individual identified upon admission to receive a discharge notice on behalf of the resident" may be the same person as the resident's legal representative or responsible person as identified in the resident's record.

(g) The facility administrator or their designee shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by:

(1) explaining to the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident why the discharge is necessary;

(2) informing the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident about an appropriate discharge destination that is capable of meeting the needs of the resident; and

(A) If at the time of the discharge notice the discharge destination is unknown or is not capable of meeting the needs of the resident, the facility administrator or their designee, shall contact the local adult care home resident discharge team as defined in G.S. 131D-4.8(e) to assist with placement; and

(B) The facility, at the direction of the administrator or their designee, shall inform the resident, the resident's legal representative, the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident, and the responsible person of their right to request the Regional Long-Term Care Ombudsman to serve as a member of the adult care home resident discharge team; and

(3) offering the following material to the resident, the resident's legal representative, or the facility where the resident is to be placed and providing this material as requested prior to or upon discharge of the resident:

(A) a copy of the resident's most current FL-2 form required in Rule .0703 of this Subchapter;

(B) a copy of the resident's most current assessment and care plan;

(C) a list of referrals to licensed health professionals, including mental health;

(D) a copy of the resident's current physician orders;

(E) a list of the resident's current medications;

(F) the resident's current medications; and

(G) a record of the resident's vaccinations and TB screening;

(4) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (c) of this Rule:

(A) the regional long-term care ombudsman; and

(B) Disability Rights North Carolina, the protection and advocacy agency established under federal law for persons with disabilities.

(5) providing the resident, responsible person, or legal representative, and the individual identified upon admission who received a copy of the discharge notice on behalf of the resident with the discharge location as determined by the adult care home resident discharge team, if convened, at or before the discharge hearing, if the location is known to the facility.

(h) If an appeal hearing is requested:

(1) the facility administrator or their designee shall provide to the resident or legal representative or the resident and the responsible person, the Hearing Unit copies of all documents and records that

the facility intends to use at the hearing at least five working days prior to the scheduled hearing; and

(2) the facility administrator or their designee shall not discharge the resident before the final decision resulting from the appeal has been rendered, except in those cases of discharge specified in Paragraph (d) of this Rule.

(i) If a discharge is initiated by the resident, the resident's legal representative, or responsible person, the administrator may require up to a 14-day written notice from the resident, the resident's legal representative, or responsible person which means the resident may be charged for the days of the required notice if notice is not given or if notice is given and the resident leaves before the end of the required notice period. Exceptions to the required notice are cases in which a delay in discharge or transfer would jeopardize the health or safety of the resident or others in the facility. The facility's requirement for a notice from the resident, the resident's legal representative, or responsible person shall be established in the resident contract provided to the resident or responsible person upon admission.

(j) The discharge requirements in this Rule do not apply when a resident is transferred to an acute inpatient facility for mental or physical health evaluation or treatment and the adult care facility's bed hold policy applies based on the expected return of the resident. If the facility administrator or their designee decides to discharge a resident who has been transferred to an acute inpatient facility and there has been no physician-documented level of care change for the resident, the discharge requirements in this Rule apply.

History Note: Authority G.S. 131D-2.1; 131D-2.16; 131D-4.8; 131D-4.5; 131D-21; 143B-165;
Temporary Adoption Eff. January 1, 2000; December 1, 1999;
Eff. April 1, 2001;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. July 1, 2004;
Readopted Eff. April 1, 2024.

SECTION .0800 - RESIDENT ASSESSMENT AND CARE PLAN

10A NCAC 13G .0801 RESIDENT ASSESSMENT

(a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter.

(b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living. The assessment instrument established by the Department shall include the following:

(1) resident identification and demographic information;
(2) current diagnoses;
(3) current medications;
(4) the resident's ability to self-administer medications;
(5) the resident's ability to perform activities of daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating;
(6) mental health history;
(7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background;
(8) mood and behaviors;
(9) nutritional status, including specialized diet or dietary needs;
(10) skin integrity;
(11) memory, orientation and cognition;
(12) vision and hearing;
(13) speech and communication;
(14) assistive devices needed; and

(15) a list of and contact information for health care providers or services used by the resident.

The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms/dma-3050r-adult-care-home-personal-care-physician/@@display-file/form_file/dma-3050R.pdf. at no cost.

(c) When a facility identifies a change in a resident's baseline condition based upon the factors listed in Parts (1)(A) through (M) of this Paragraph, the facility shall monitor the resident's condition for no more than 10 days to determine if a significant change in the resident's condition has occurred. The facility shall conduct an assessment of a resident within three days after the facility identifies that a significant change in the resident's baseline condition has occurred. The facility shall use the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows:

(1) Significant change is one or more of the following:
  (A) deterioration in two or more activities of daily living including bathing, dressing, personal hygiene, toileting, or eating;
  (B) change in ability to walk or transfer, including falls if the resident experiences repeated falls, meaning more than one, on the same day, or multiple falls that occur over several days to weeks, new onset of falls not attributed to an identifiable cause, a fall with consequent change in neurological status, or physical injury;
  (C) Pain worsening in severity, intensity, or duration, occurring in a new location, or new onset of pain associated with trauma;
  (D) change in the pattern of usual behavior, new onset of resistance to care, abrupt onset or progression of agitation or combative behavior, deterioration in affect or mood, or violent or destructive behaviors directed at self or others.
  (E) no response by the resident to the intervention for an identified problem;
  (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period;
  (G) when a resident has been enrolled in hospice;
  (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or any pressure ulcer determined to be greater than Stage II;
  (I) a new diagnosis of a condition which affects the resident's physical, mental, or psychosocial well-being;
  (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer meets the resident's needs;
  (K) new onset of impaired decision-making;
  (L) continence to incontinence or indwelling catheter; or
  (M) the resident's condition indicates there may be a need to use a restraint in accordance with Rule .1301 of this Subchapter and there is no current restraint order for the resident.
(2) Significant change does not include the following:
  (A) changes that resolve with or without intervention;
  (B) an acute illness or episodic event. For the purposes of this Rule "acute illness" means symptoms or a condition that develops quickly and is not a part of the resident's baseline physical health or mental health status;
  (C) an established, predictable, cyclical pattern; or
  (D) steady improvement under the current course of care.

(d) If a resident experiences a significant change as defined in Paragraph (c) of this Rule, the facility shall refer the resident to the resident's physician or other licensed health professional no longer than three days from the date of the significant change assessment, and document the referral in the resident's record. Referral shall be made immediately when facility staff determines that a significant change as defined in Parts (c)(1)(A)-(M) of this Rule poses an immediate risk to the health and safety of the resident, other residents, or staff of the facility.

(e) The assessments required in Paragraphs (a) and (c) of this Rule shall be completed and signed by the person designated by the administrator to perform resident assessments.

History Note: Authority G.S. 131D-2.15; 131D-2.16; 131D-4.4; 131D-4.5; 143B-165;
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. December 1, 1999;

Amended Eff. July 1, 2000;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. July 1, 2005; June 1, 2004;
Readopted Eff. June 1, 2025.

10A NCAC 13G .0802 RESIDENT CARE PLAN

(a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan.
(b) The resident shall be offered the opportunity to participate in the development of his or her care plan. If the resident is unable to participate in the development of the care plan due to cognitive impairment, the responsible person as defined in Rule .0102 of this Subchapter shall be offered the opportunity to participate in the development of the care plan.
(c) The care plan shall include the following:

(1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section;
(2) frequency of the services or tasks to be performed;
(3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section;
(4) licensed health professional tasks required according to Rule .0903 of this Section;
(5) a dated signature of the assessor upon completion; and
(6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid.

(d) If the resident received home health or hospice services, the facility shall communicate with the home health or hospice agency to coordinate care and services to ensure the resident's needs are met.
(e) The facility shall assure that the care plan for each resident who is under the care of a provider of mental health, developmental disabilities or substance use services includes instructions regarding how to contact that provider, including emergency and after-hours contacts. Whenever significant behavioral changes described in Rule .0801(c)(1)(D) of this Subchapter are identified, the facility shall refer the resident to a provider of mental health, developmental disabilities or substance use services in accordance with Rule .0801(d) of this Subchapter.
(f) The care plan shall be revised as needed based on the results of a significant change assessment completed in accordance with Rule .0801 of this Section.

History Note: Authority G.S. 131D-2.15; 131D-2.16; 131D-4.3; 131D-4.4; 131D-4.5; 143B-165;
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. January 1, 2001;
Temporary Amendment Expired October 13, 2001;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. July 1, 2005; June 1, 2004;
Readopted Eff. June 1, 2025.

SECTION .0900 – RESIDENT CARE AND SERVICES

10A NCAC 13G .0901 PERSONAL CARE AND SUPERVISION

(a) Family care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.

(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.
(c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.

History Note: Authority G.S. 131D-2.16; 131D-4.3; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; May 1, 1999; July 1, 1990; April 1, 1987; April 1, 1984;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .0902 HEALTH CARE
(a) A family care home shall provide care and services in accordance with the resident's care plan.
(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.
(c) The facility shall assure documentation of the following in the resident's record:

(1) facility contacts with the resident's physician, physician service, other licensed health professional, including mental health professional, when illnesses or accidents occur and any other facility contacts with a physician or licensed health professional regarding resident care;
(2) all visits of the resident to or from the resident's physician, physician service or other licensed health professional, including mental health professional, of which the facility is aware.
(3) written procedures, treatments or orders from a physician or other licensed health professional; and
(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.

(d) The following shall apply to the resident's physician or physician service:

(1) The resident or the resident's responsible person shall be allowed to choose a physician or physician service to attend the resident.
(2) When the resident cannot remain under the care of the chosen physician or physician service, the facility shall assure that arrangements are made with the resident or responsible person for choosing and securing another physician or physician service within 45 days or prior to the signing of the care plan as required in Rule .0802 of this Subchapter.

History Note: Authority G.S. 131D-2.16; 131D-4.3; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. December 1, 1993; May 1, 1992, July 1, 1990; September 1, 1987;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. July 1, 2005; June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .0903 LICENSED HEALTH PROFESSIONAL SUPPORT
(a) The facility shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan, and care provided for residents requiring one or more of the following personal care tasks:

(1) applying and removing ace bandages, TED hose, binders, and braces and splints;
(2) feeding techniques for residents with swallowing problems;
(3) bowel or bladder training programs to regain continence;
(4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches;
(5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter;
(6) chest physiotherapy or postural drainage;
(7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents;
(8) collecting and testing of fingerstick blood samples;

(9) care of well-established colostomy or ileostomy. For the purpose of this Rule, "well-established colostomy or ileostomy" means having a healed surgical site without sutures or drainage;
(10) care for pressure ulcers, up to and including a Stage II pressure ulcer, which is a superficial ulcer presenting as an abrasion, blister, or shallow crater;
(11) inhalation medication by machine;
(12) forcing and restricting fluids;
(13) maintaining accurate intake and output data;
(14) medication administration through a well-established gastrostomy feeding tube. For the purpose of this Rule, "well-established gastrostomy feeding tube" means having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established;
(15) medication administration through subcutaneous injection in accordance with Rule .1004(q) except for anticoagulant medications;
(16) oxygen administration and monitoring;
(17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints;
(18) oral suctioning;
(19) care of well-established tracheostomy, not to include endotracheal suctioning. For the purpose of this Rule, "well-established tracheostomy" means the stoma is well-healed and the airway is patent;
(20) administering and monitoring of tube feedings through a well-established gastrostomy feeding tube in accordance with Subparagraph (a)(14) of this Rule;
(21) the monitoring of continuous positive air pressure devices (CPAP and BIPAP);
(22) application of prescribed heat therapy;
(23) application and removal of prosthetic devices except as used in post-operative treatment for shaping of the extremity;
(24) ambulation using assistive devices that requires physical assistance;
(25) range of motion exercises;
(26) any other prescribed physical or occupational therapy;
(27) transferring semi-ambulatory or non-ambulatory residents; or
(28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that Act in 21 NCAC 36.

(b) The appropriate licensed health professional, as required in Paragraph (a) of this Rule, is:
(1) a registered nurse licensed under G.S. 90, Article 9A, for tasks listed in Subparagraphs (a)(1) through (28) of this Rule;
(2) an occupational therapist licensed under G.S. 90, Article 18D or physical therapist licensed under G.S. 90-270.90, Article 18E, for tasks listed in Subparagraphs (a)(17) and (a)(22) through (27) of this Rule;
(3) a respiratory care practitioner licensed under G.S. 90, Article 38, for tasks listed in Subparagraphs (a)(6), (11), (16), (18), (19), and (21) of this Rule; or
(4) a registered nurse licensed under G.S. 90, Article 9A, for tasks that can be performed by a nurse aide II according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that Act in 21 NCAC 36.

(c) The facility shall assure that participation by a registered nurse, occupational therapist, respiratory care practitioner, or physical therapist in the on-site review and evaluation of the residents' health status, care plan, and care provided, as required in Paragraph (a) of this Rule, is completed within 30 days after admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following:
(1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;
(2) evaluating the resident's progress to care being provided;
(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and
(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

(d) The facility shall follow-up and implement recommendations made by the licensed health professional including referral to the physician or appropriate health professional when indicated. The facility shall document follow-up on all recommendations made by the licensed health professional.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0904 NUTRITION AND FOOD SERVICE

(a) Food Procurement and Safety in Family Care Homes:

(1) Food services shall comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food under sanitary conditions.

(2) Only meat processed at a USDA-approved processing plant shall be served.

(3) There shall be a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus established in Paragraph (c) of this Rule, for both regular and therapeutic diets. For the purpose of this Rule "perishable food" is food that is likely to spoil or decay if not kept refrigerated at 40 degrees Fahrenheit or below, or frozen at zero degrees Fahrenheit or below and "non-perishable food" is food that can be stored at room temperature and is not likely to spoil or decay within seven days.

(b) Food Preparation and Service in Family Care Homes:

(1) Table service shall include a napkin and non-disposable place setting consisting of a knife, fork, spoon, plate, and beverage containers.

(2) Hot foods shall be served hot and cold foods shall be served cold as set forth in Rule 15A NCAC 18A .1620(a) which is hereby incorporated by reference, including subsequent amendments.

(3) If residents require feeding assistance, food shall be maintained at serving temperature until assistance is provided.

(c) Menus in Family Care Homes:

(1) Menus shall be prepared at least one week in advance with serving quantities specified and in accordance with the daily food requirements in Paragraph (d) of this Rule.

(2) Menus shall be maintained in the kitchen and identified as to the current menu day for guidance of food service staff.

(3) Any substitutions made in the menu shall be of equal nutritional value, in order to maintain the daily dietary requirements in Subparagraph (d)(3) of this Rule, appropriate for therapeutic diets, and documented in records maintained in the kitchen to indicate the foods actually served to residents.

(4) Menus shall be planned to take into account the food preferences of the residents as documented on the Resident Register.

(5) Menus as served, invoices, and other receipts for food or beverage purchases shall be maintained in the facility for 30 days.

(6) Menus for all therapeutic diets shall be planned or reviewed by a licensed dietitian/nutritionist. The facility shall maintain verification of the licensed dietitian/nutritionist's approval of the therapeutic diets.

(7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff.

(d) Food Requirements in Family Care Homes:

(1) Each resident shall be served a minimum of three nutritionally adequate meals based on the requirements in Subparagraph (d)(3) of this Rule. Meals shall be served at regular times comparable to normal meal times in the community. There shall be at least 10 hours between the breakfast and evening meals.

(2) Foods and beverages shall be offered in accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.

(3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary Guidelines for Americans 2020-2025, which are hereby incorporated by reference, including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf, at no cost.

(4) Water shall be served to each resident at each meal, in addition to other beverages.

(e) Therapeutic Diets in Family Care Homes:

(1) All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician. Where applicable, the therapeutic diet order shall be specific to calorie, gram, or consistency, such as for calorie-controlled ADA diets, low sodium diets, or thickened liquids, unless there are written orders that include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a licensed dietitian/nutritionist. For the purpose of this Rule "therapeutic diet" is a diet ordered by a physician, physician assistant, nurse practitioner, or a licensed dietician/nutritionist as delegated by the physician that is part of the treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium or potassium), or to provide mechanically altered food when indicated.

(2) Physician orders for nutritional supplements shall be in writing from the resident's physician and be brand-specific, unless the facility has defined a house supplement in its communication to the physician, and shall specify quantity and frequency.

(3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.

(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.

(f) Individual Feeding Assistance in Family Care Homes:

(1) The facility shall provide staff for individual feeding assistance as in accordance with residents' needs.

(2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.

(g) Variations from the required three meals or time intervals between meals to meet individualized needs or preferences of residents shall be documented in the resident's record. Each resident shall receive three meals in accordance with resident preferences as documented in the resident's record.

History Note: *Authority G.S. 131D-2.1(4); 131D-2.16; 131D-4.4; 143B-165;*
Eff. January 1, 1977;
Amended Eff. October 1, 1977; April 22, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. August 3, 1992; July 1, 1990; September 1, 1987; April 1, 1987;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Readopted Eff. March 1, 2023.

10A NCAC 13G .0905 ACTIVITIES PROGRAM

(a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community.

(b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities.

(c) The activity director shall:

(1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities, and possible cultural differences of the residents;

(2) prepare a monthly calendar of planned group activities in a format that is legible and shall be posted in a location accessible to residents by the first day of each month, and updated when there are any changes;

(3) involve community resources, such as recreational, volunteer, and religious organizations, to enhance the activities available to residents;

(4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program;

(5) encourage residents to participate in activities; and

(6) assure there are supplies necessary for planned activities, supervision, and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities.

(d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills.

(e) Residents shall have the opportunity to participate in activities involving one to one interaction and activity by oneself that promote enjoyment, a sense of accomplishment, increased knowledge, learning of new skills, and creative expression.

(f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so.

(g) Residents shall have the opportunity to participate in volunteer service activities in the facility or in the community. Participation in volunteer activities shall not be required of residents and shall not involve any duties or responsibilities that are outlined in the job descriptions of facility staff.

History Note: Authority G.S. 131D-2.16; 131D-4.1; 131D-4.3;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. August 3, 1992; April 1, 1987; April 1, 1984;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0906 OTHER RESIDENT SERVICES

(a) Transportation. The administrator must assure the provision of transportation for the residents to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the resident's choice. The resident is not to be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members as well as facility vehicles.

(b) Mail.

(1) Residents shall receive their mail promptly and it must be unopened unless there is a written, witnessed request authorizing management staff to open and read mail to the resident. This request must be recorded on Form DSS-1865, the Resident Register or the equivalent;

(2) Outgoing mail written by a resident shall not be censored; and

(3) Residents shall be encouraged and assisted, if necessary, to correspond by mail with close relatives and friends. Residents shall have access to writing materials, stationery and postage and, upon request, the home is to provide such items at cost. It is not the home's obligation to pay for these items.

(c) Laundry.

(1) Laundry services must be provided to residents without any additional fee; and

(2) It is not the home's obligation to pay for a resident's personal dry cleaning. The resident's plans for personal care of clothing are to be indicated on Form DSS-1865, the Resident Register.

(d) Telephone.

(1) A telephone must be available in a location providing privacy for residents to make and receive a reasonable number of calls of a reasonable length;

(2) A pay station telephone is not acceptable for local calls; and

(3) It is not the home's obligation to pay for a resident's toll calls.

(e) Personal Lockable Space.

(1) Personal lockable space must be provided for each resident to secure his personal valuables. One key shall be provided free of charge to the resident. Additional keys are to be provided to residents at cost upon request. It is not the home's obligation to pay for additional keys; and

(2) While a resident may elect not to use lockable space, it must still be available in the home since the resident may change his mind. This space shall be accessible only to the resident and the administrator or supervisor-in-charge. The administrator or supervisor-in-charge must determine at admission whether the resident desires lockable space, but the resident may change his mind at any time.

(f) Visiting.

(1) Visiting in the home and community at reasonable hours shall be encouraged and arranged through the mutual prior understanding of the residents and administrator;

(2) There must be at least 10 hours each day for visitation in the home by persons from the community. If a home has established visiting hours or any restrictions on visitation, information about the hours and any restrictions must be included in the house rules given to each resident at the time of admission and posted conspicuously in the home;

(3) A signout register must be maintained for planned visiting and other scheduled absences which indicates the resident's departure time, expected time of return and the name and telephone number of the responsible party;

(4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home must immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. December 1, 1991; April 1, 1987; April 1, 1984;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .0907 RESPITE CARE

(a) For the purposes of this Subchapter, respite care is defined as supervision, personal care and services provided for persons admitted to a family care home on a temporary basis for temporary caregiver relief, not to exceed 30 days.

(b) Respite care is not required as a condition of licensure. However, respite care is subject to the requirements of this Subchapter except for Rules .0703, .0705, .0801, .0802 and .1201.

(c) The number of respite care residents and family care home residents shall not exceed the facility's licensed bed capacity.

(d) The respite care resident contract shall specify the rates for respite care services and accommodations, the date of admission to the facility and the proposed date of discharge from the facility. The contract shall be signed by the administrator or designee and the respite care resident or his responsible person and a copy given to the resident and responsible person.

(e) Upon admission of a respite care resident into the facility, the facility shall assure that the resident has a current FL-2 and been tested for tuberculosis disease according to Rule .0702 of this Subchapter and that there are current physician orders for any medications, treatments and special diets for inclusion in the respite care resident's record. The facility shall assure that the respite care resident's physician or prescribing practitioner is contacted for verification of orders if the orders are not signed and dated within seven calendar days prior to admission to the facility as a respite care resident or for clarification of orders if orders are not clear or complete.

(f) The facility shall complete an assessment which allows for the development of a short-term care plan prior to or upon admission to the facility with input from the resident or responsible person. The assessment shall address respite resident needs, including identifying information, hearing, vision, cognitive ability, functional limitations, continence, special procedures and treatments as ordered by physician, skin conditions, behavior and mood, oral and nutritional status and medication regimen. The facility may use the Resident Register or an equivalent as the assessment instrument. The care plan shall be signed and dated by the facility's administrator or designated representative and the respite care resident or responsible person.

(g) The respite care resident's record shall include a copy of the signed respite care contract; the FL-2; the assessment and care plan; documentation of a tuberculosis test according to Paragraph (e) of this Rule; documentation of any contacts (office, home or telephone) with the resident's physician or other licensed health professionals from outside the facility; physician orders; medication administration records; a statement, signed and dated by the resident or responsible person, indicating that information on the home as required in Rule .0704 of this

Subchapter has been received; a written description of any acute changes in the resident's condition or any incidents or accidents resulting in injury to the respite care resident, and any action taken by the facility in response to the changes, incidents or accidents; and how the responsible person or his designated representative can be contacted in case of an emergency.

(h) The respite care resident's responsible person or his designated representative shall be contacted and informed of the need to remove the resident from the facility if one or more of the following conditions exists:

(1) the resident's condition is such that he is a danger to himself or poses a direct threat to the health of others as documented by a physician; or

(2) the safety of individuals in the home is threatened by the behavior of the resident as documented by the facility.

Documentation of the emergency discharge shall be on file in the facility.

History Note: Authority G.S. 131D-2.16; 143B-165;
Temporary Adoption Eff. November 1, 2000;
Eff. July 18, 2002;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .0908 COOPERATION WITH CASE MANAGERS

History Note: Authority G.S. 131D-2.16; 131D-4.3; 143B-165;
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Expired Eff. March 1, 2019 pursuant to G.S. 150B-21.3A.

10A NCAC 13G .0909 RESIDENT RIGHTS

A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

History Note: Authority G.S. 131D-2.16; 131D-21; 143B-165;
Temporary Adoption Eff. July 1, 2004;
Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

SECTION .1000 – MEDICATIONS

10A NCAC 13G .1001 MEDICATION ADMINISTRATION POLICIES AND PROCEDURES

In addition to the requirements in Rule .1211(a)(1) of this Subchapter, a family care home shall ensure the following:

(1) orientation to medication policies and procedures for staff responsible for medication administration prior to their administering or supervising the administration of medications; and

(2) compliance of medication policies and procedures with requirements of this Section and all applicable state and federal regulations, including definitions in the North Carolina Pharmacy Practice Act, G.S. 90-85.3.

For the purposes of this Subchapter, medications include herbal and non-herbal supplements.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Amended Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .1002 MEDICATION ORDERS

(a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:

(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;

(2) if orders are not clear or complete; or

(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.

The facility shall ensure that this verification or clarification is documented in the resident's record.

(b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility.

(c) The medication orders shall be complete and include the following:

(1) medication name;

(2) strength of medication;

(3) dosage of medication to be administered;

(4) route of administration;

(5) specific directions of use, including frequency of administration; and

(6) if ordered on an as needed basis, a stated indication for use.

(d) Verbal orders for medications and treatments shall be:

(1) countersigned by the prescribing practitioner within 15 days from the date the order is given;

(2) signed or initialed and dated by the person receiving the order; and

(3) accepted only by a licensed professional authorized by state occupational licensure laws to accept orders or staff responsible for medication administration.

(e) Any standing orders shall be for individual residents and signed and dated by the resident's physician or prescribing practitioner.

(f) The facility shall assure that all current orders for medications or treatments, including standing orders and orders for self-administration, are reviewed and signed by the resident's physician or prescribing practitioner at least every six months.

(g) In addition to the requirements as stated in Paragraph (c) of this Rule, psychotropic medications ordered "as needed" by a prescribing practitioner, shall not be administered unless the following have been provided by the practitioner or included in an individualized care plan developed with input by a registered nurse or licensed pharmacist:

(1) detailed behavior-specific written instructions, including symptoms that might require use of the medication;

(2) exact dosage;

(3) exact time frames between dosages; and

(4) the maximum dosage to be administered in a twenty-four hour period.

(h) The facility shall assure that personal care aides and their direct supervisors receive training annually about the desired and undesired effects of psychotropic medications, including alternative behavior interventions. Documentation of training attended by staff shall be maintained in the facility.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Amended Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .1003 MEDICATION LABELS

(a) Labeling of prescription legend medications, except for medications prepared for a resident's leave of absence in accordance with Rule .1010(d)(4) of this Section, shall be legible and include the following information:

(1) the name of the resident for whom the medication is prescribed;

(2) the most recent date of issuance;

(3) the name of the prescriber;

(4) the name and concentration of the medication, quantity dispensed, and prescription serial number;

(5) unabbreviated directions for use stated;

(6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed;
(7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date;
(8) auxiliary information as required of the medication;
(9) the name, address, and telephone number of the dispensing pharmacy; and
(10) the name or initials of the dispensing pharmacist.

(b) For medication systems in which two or more prescribed solid oral dosage forms are packaged and dispensed together, labeling shall be in accordance with Paragraph (a) of this Rule and the label or package shall also have a physical description or identification of each medication contained in the package.

(c) The facility shall assure any changes in directions of a resident's medication by the prescriber are on the container at the refilling of the medication by the pharmacist or dispensing practitioner. The facility shall have a procedure for identifying direction changes until the container is correctly labeled in accordance with Paragraph (a) of this Rule. No person other than a licensed pharmacist or dispensing practitioner shall alter a prescription label.

(d) Non-prescription medications shall have the manufacturer's label with the expiration date visible, unless the container has been labeled by a licensed pharmacist or a dispensing practitioner in accordance with Paragraph (a) of this Rule. Non-prescription medications in the original manufacturer's container shall be labeled with at least the resident's name and the name shall not obstruct any of the information on the container. Facility staff may label or write the resident's name on the container.

(e) Medications, prescription and non-prescription, shall not be transferred from one container to another except when prepared for a resident's leave of absence or administration to a resident.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Amended Eff. April 1, 2015;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .1004 MEDICATION ADMINISTRATION

(a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

(b) The facility shall assure that only staff meeting the requirements in Rule .0403 of this Subchapter shall administer medications, including the preparation of medications for administration.

(c) Only oral solid medications that are ordered for routine administration may be prepared in advance and must be prepared within 24 hours of the prescribed time for administration. Medications prescribed for prn (as needed) administration shall not be prepared in advance.

(d) Liquid medications, including powders or granules that require to be mixed with liquids for administration, and medications for injection shall be prepared immediately before administration to a resident.

(e) Medications shall not be crushed for administration until immediately before the medications are administered to the resident.

(f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage:
(1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container;
(2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name;
(3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and

(4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section.

(g) The facility shall ensure that medications are administered within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations.

(h) If medications are not prepared and administered by the same staff person, there shall be documentation for each dose of medication prepared for administration by the staff person who prepared the medications when or at the time the resident's medication is prepared. Procedures shall be established and implemented to identify the staff person who prepared the medication and the staff person who administered the medication.

(i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

(j) The resident's medication administration record (MAR) shall be accurate and include the following:

(1) resident's name;
(2) name of the medication or treatment order;
(3) strength and dosage or quantity of medication administered;
(4) instructions for administering the medication or treatment;
(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

(k) The facility shall have a system in place to ensure the resident is identified prior to the administration of any medication or treatment.

(l) The facility shall assure the development and implementation of policies and procedures governing medication errors and adverse medication reactions that include documentation of the following:

(1) notification of a physician or appropriate health professional and supervisor;
(2) action taken by the facility according to orders by the physician or appropriate health professional; and
(3) charting or documentation errors, unavailability of a medication, resident refusal of medication, any adverse medication reactions and notification of the resident's physician when necessary.

(m) Medication administration supplies, such as graduated measuring devices, shall be available and used by facility staff in order for medications to be accurately and safely administered.

(n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.

(o) A resident's medication shall not be administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly and that the borrowing and replacement of the medication shall be documented.

(p) Only oral, topical (including ophthalmic and otic medications), inhalants, rectal and vaginal medications, subcutaneous injections and medications administered by gastrostomy tube and nebulizers may be administered by persons who are not authorized by state occupational licensure laws to administer medication.

(q) Unlicensed staff may not administer insulin or other subcutaneous injections prior to meeting the requirements for training and competency validation as stated in Rules .0504 and .0505 of this Subchapter.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Amended Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .1005 SELF-ADMINISTRATION OF MEDICATIONS

(a) The facility shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met:

(1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and

(2) specific instructions for administration of prescription medications are printed on the medication label.

(b) The facility shall notify the physician when:

(1) there is a change in the resident's mental or physical ability to self-administer;

(2) the resident is non-compliant with the physician's orders; or

(3) the resident is non-compliant with the facility's medication policies and procedures.

A resident's right to refuse medications does not imply the inability of the resident to self-administer medications.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Readopted Eff. October 1, 2022.

10A NCAC 13G .1006 MEDICATION STORAGE

(a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified by the facility's medication storage policy and procedures.

(b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration.

(c) The medication storage area shall be routinely cleaned, include functional lighting, ventilated to circulate fresh air, large enough to store medications in an orderly manner, and located in areas other than the bathroom, kitchen or utility room. Medication carts shall be routinely cleaned and medications shall be stored in an orderly manner.

(d) Locked storage areas for medications shall only be by staff responsible for medication administration, the administrator, or the administrator-in-charge.

(e) Medications intended for topical or external use, except for ophthalmic, otic, and transdermal medications, shall be stored in a designated area separate from the medications intended for oral and injectable use. Ophthalmic, otic, and transdermal medications may be stored with medications intended for oral and injectable use. Medications shall be stored apart from cleaning agents and hazardous chemicals.

(f) Medications requiring refrigeration shall be stored at 36 degrees F to 46 degrees F (2 degrees C to 8 degrees C).

(g) Medications shall not be stored in a refrigerator containing non-medications and non-medication related items, except when stored in a separate container. The container shall be locked when storing medications unless the refrigerator is locked or is located in a locked medication area.

(h) The facility shall only possess a stock of non-prescription medications or the following prescription legend medications for general or common use in accordance with physicians' orders:

(1) irrigation solutions in single unit quantities exceeding 49 ml. and related diagnostic agents;

(2) diagnostic agents;

(3) vaccines; and

(4) water for injection and normal saline for injection.

(i) First aid supplies shall be immediately available to staff within the facility, stored out of sight of residents and visitors, and stored separately from medications.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Readopted Eff. October 1, 2022.

10A NCAC 13G .1007 MEDICATION DISPOSITION

(a) Medications shall be released to or with a resident upon discharge if the resident has a physician's order to continue the medication. Prescribed medications are the property of the resident and shall not be given to, or taken by, other staff or residents according to Rule .1004(o) of this Subchapter.

(b) Medications, excluding controlled medications, that are expired, discontinued, prescribed for a deceased resident or deteriorated shall be stored separately from actively used medications until disposed of.
(c) Medications, excluding controlled medications, shall be destroyed at the facility or returned to a pharmacy within 90 days of the expiration or discontinuation of medication or following the death of the resident.
(d) All medications destroyed at the facility shall be destroyed by the administrator or the administrator's designee and witnessed by a pharmacist, a dispensing practitioner, or their designee. The destruction shall be conducted so that no person can use, administer, sell or give away the medication.
(e) Records of medications destroyed or returned to the pharmacy shall include the resident's name, the name and strength of the medication, the amount destroyed or returned, the method of destruction if destroyed in the facility and the signature of the administrator or the administrator's designee and the signature of the pharmacist, dispensing practitioner or their designee. These records shall be maintained by the facility for a minimum of one year.
(f) A dose of any medication prepared for administration and accidentally contaminated or not administered shall be destroyed at the facility according to the facility's policies and procedures.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .1008 CONTROLLED SUBSTANCES

(a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.
(b) Controlled substances may be stored together in a common location or container. If Schedule II medications are stored together in a common location, the Schedule II medications shall be under double lock.
(c) Controlled substances that are expired, discontinued or no longer required for a resident shall be returned to the pharmacy within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The facility shall document the resident's name; the name, strength and dosage form of the controlled substance; and the amount returned. There shall also be documentation by the pharmacy of the receipt or return of the controlled substances.
(d) If the pharmacy will not accept the return of a controlled substance, the administrator or the administrator's designee shall destroy the controlled substance within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The destruction shall be witnessed by a licensed pharmacist, dispensing practitioner, or designee of a licensed pharmacist or dispensing practitioner. The destruction shall be conducted so that no person can use, administer, sell or give away the controlled substance. Records of controlled substances destroyed shall include the resident's name; the name, strength and dosage form of the controlled substance; the amount destroyed; the method of destruction; and, the signature of the administrator or the administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner.
(e) Records of controlled substances returned to the pharmacy or destroyed by the facility shall be maintained by the facility for a minimum of three years.
(f) Controlled substances that are expired, discontinued, prescribed for a deceased resident or deteriorated shall be stored securely in a locked area separately from actively used medications until disposed of.
(g) A dose of a controlled substance accidentally contaminated or not administered shall be destroyed at the facility. The destruction shall be documented on the medication administration record (MAR) or the controlled substance record showing the time, date, quantity, manner of destruction and the initials or signature of the person destroying the substance.
(h) The facility shall ensure that all known drug diversions are reported to the pharmacy, the local law enforcement agency and Health Care Personnel Registry as required by state law and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Amended Eff. July 1, 2005;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .1009 PHARMACEUTICAL CARE

(a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following:

(1) an on-site medication review for each resident which includes at least the following:

(A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and,

(B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and,

(C) documenting the results of the medication review in the resident's record;

(2) review of all aspects of medication administration including the observation or review of procedures for the administration of medications and inspection of medication storage areas;

(3) review of the medication system utilized by the facility, including packaging, labeling and availability of medications;

(4) review the facility's procedures and records for the disposition of medications and provide assistance, if necessary;

(5) provision of a written report of findings and any recommendations for change for Items (1) through (4) of Paragraph (a) of this Rule to the facility and the physician or appropriate health professional, when necessary;

(6) conducting in-service programs as needed for facility staff on medication usage that includes, but not limited to the following:

(A) potential or current medication related problems identified;

(B) new medications;

(C) side effects and medication interactions; and

(D) policies and procedures.

(b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary.

(c) The facility shall maintain the findings and reports resulting from the activities in Subparagraphs (1) through (6) of Paragraph (a) of this Rule in the facility, including action taken by the facility.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .1010 PHARMACEUTICAL SERVICES

(a) A family care home shall allow the residents the right to choose a pharmacy provider as long as the pharmacy provides services that are in accordance with requirements of this Section and all applicable state and federal regulations and the facility's medication management policies and procedures.

(b) There shall be a current, written agreement with a licensed pharmacist or a prescribing practitioner for pharmaceutical care services in accordance with Rule .1009 of this Section. The written agreement shall include a statement of the responsibility of each party.

(c) The facility shall assure the provision of pharmaceutical services to meet the needs of the residents including procedures that assure the accurate ordering, receiving and administering of all medications prescribed on a routine, emergency, or as needed basis.

(d) The facility shall assure the provision of medication for residents on temporary leave from the facility or involved in day activities out of the facility. The facility shall have written policies and procedures for a resident's temporary leave of absence. The policies and procedures shall facilitate safe administration by assuring that upon receipt of the medication for a leave of absence the resident or the person accompanying the resident is able to identify the medication, dosage, and administration time for each medication provided for the temporary leave of absence. The policies and procedures shall include at least the following provisions:

(1) The amount of resident's medications provided shall be sufficient and necessary to cover the duration of the resident's absence. For the purposes of this Rule, sufficient and necessary means the amount of medication to be administered during the leave of absence or only a current dose pack, card, or container if the current dose pack, card, or container has enough medication for the planned absence;

(2) Written and verbal instructions for each medication to be released for the resident's absence shall be provided to the resident or the person accompanying the resident upon the medication's release from the facility and shall include at least:

  (A) the name and strength of the medication;

  (B) the directions for administration as prescribed by the resident's physician;

  (C) any cautionary information from the original prescription package if the information is not on the container released for the leave of absence;

(3) The resident's medications shall be provided in a capped or closed container that will protect the medications from contamination and spillage; and

(4) Labeling of each of the resident's individual medication containers for the leave of absence shall be legible, include at least the name of the resident and the name and strength of the medication, and be affixed to each container.

The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation of the quantities of medications released from and returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications' release from and return to the facility.

(e) The facility shall assure that accurate records of the receipt, use, and disposition of medications are maintained in the facility and available upon request for review.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. July 1, 2005;
Amended Eff. April 1, 2015;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

SECTION .1100 – MANAGEMENT OF RESIDENT'S FUNDS AND REFUNDS

10A NCAC 13G .1101 MANAGEMENT OF RESIDENT'S FUNDS

(a) Residents shall manage their own funds if possible.

(b) In situations where a resident is unable to manage his funds, a legal representative or payee shall be designated in accordance with Rule .1102 of this Section.

(c) Residents shall endorse checks made out to them unless a legal representative or payee has been authorized to endorse checks.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 1984;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .1102 AUTHORIZED REPRESENTATIVE

(a) In situations where the facility determines a resident of a family care home is unable to manage their monetary funds the administrator shall contact a family member, responsible person, or the county department of social

services regarding the need for an authorized representative. For the purposes of this Section, an "authorized representative" shall mean a person who is legally authorized or designated in writing by the resident to act on his or her behalf in the management of their funds.
(b) The administrator and other staff of the facility shall not serve as a resident's authorized representative, payee, or executor of a will, except in the case of funds administered by the Social Security Administration, the Veteran's Administration or other federal government agencies. The administrator of the facility may serve as a payee when so authorized as a legally constituted authority by the respective federal agencies.
(c) The administrator shall give the resident's authorized representative receipts for any monies received on behalf of the resident.

History Note: *Authority G.S. 35A-1203; 108A-37; 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 1984;
Readopted Eff. June 1, 2024.

10A NCAC 13G .1103 ACCOUNTING FOR RESIDENT'S PERSONAL FUNDS
(a) To document a resident's receipt of the State-County Special Assistance personal needs allowance after payment of the cost of care, a statement shall be signed by the resident or marked by the resident. If the statement is marked by the resident, there shall be one witness signature. For residents who have been adjudicated incompetent, the signature of the resident's authorized representative shall be required. Witnesses cannot include the staff handling the residents' personal funds transactions. The statement shall be maintained in the facility.
(b) No employee of a facility shall handle the personal funds for a resident, except for the facility administrator or the administrator's designee after having received prior written authorization from the resident or the resident's authorized representative. The facility administrator or their designee shall maintain an accurate account balance and accounting of all funds received, disbursements, and the balance on hand which shall be available upon request to the resident or their authorized representative during the facility's regular business office hours.
(c) The facility shall provide each resident or the resident's authorized representative a written monthly accounting of the resident's funds handled by the administrator or the administrator's designee. The facility shall maintain at the facility a record signed by the resident or their authorized representative indicating whether the resident or their authorized representative agrees that the monthly accounting is accurate. The records shall be maintained by the facility for at least one year.
(d) A resident's personal funds shall not be commingled with facility funds. The facility shall not commingle the personal funds of residents in an interest-bearing account.
(e) All or any portion of a resident's personal funds shall be available to the resident or their authorized representative upon request during the facility's established business days and hours except as provided in Rule .1105 of this Subchapter.
(f) The resident's personal needs allowance shall be credited to the resident's account within one business day of the funds being available in the facility's resident personal funds account.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. April 1, 1984;
Amended Eff. July 1, 2005; April 1, 1987;
Readopted Eff. June 1, 2024.

10A NCAC 13G .1104 REFUND POLICY
A family care home's refund policy shall be in writing and signed by the administrator. A copy shall be given to the resident or the resident's responsible person at time of admission. A copy shall also be filed in the resident's record.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; July 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .1105 REFUND OF PERSONAL FUNDS

(a) When the administrator or the administrator's designee handles a resident's personal money at the resident's or his payee's request, the balance shall be given to the resident or the resident's responsible person within 14 days of the resident's leaving a family care home.

(b) If a resident dies, the administrator of his estate or the Clerk of Superior Court, when no administrator for his estate has been appointed, shall be given all of his personal funds within 30 days after death.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 1984;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .1106 SETTLEMENT OF COST OF CARE

(a) If a resident of a family care home, has been notified by the facility of its intent to discharge in accordance with Rule .0705 of this Subchapter, the facility shall refund the resident an amount equal to the cost of care for the remainder of the month minus the amount charged for any nights spent in the facility during the notice period. The refund shall be made within 14 days after the resident leaves the facility. For the purposes of this Rule, "cost of care" means any monies paid by the resident or the resident's legal representative in advance for room and board and services provided by facility as agreed upon in the resident's contract.

(b) When a resident moves out of the facility without giving notice, as may be required by the facility according to Rule .0705(i) of this Subchapter, or before the facility's required notice period has elapsed, the facility shall charge the resident no more than the amount equal to the cost of care for the required notice period. If a resident receiving State-County Special Assistance moves without giving notice or before the notice period has elapsed, the facility may charge the resident for the required notice period. The facility shall refund the resident the remainder of any advance payment following settlement of the cost of care. The refund shall be made within 14 days from the date of notice or, if no notice is given, within 14 days of the resident leaving the facility.

(c) When there is an exception to the notice as provided in Rule .0705(i) of this Subchapter to protect the health or safety of the resident or others in the facility, or when there is a sudden, unexpected closure of the facility that requires the resident to relocate, the facility shall only charge the resident for any nights spent in the facility. A refund shall be made to the resident by the facility within 14 days from the date of notice.

(d) When a resident gives notice of leaving the facility, as may be required by the facility according to Rule .0705(i) of this Subchapter, and leaves at the end of the notice period, the facility shall refund the resident the remainder of any advance payment within 14 days from the date of notice. If notice is not required by the facility, the refund shall be made within 14 days after the resident leaves the facility.

(e) When a resident leaves the facility and the resident or his or her responsible person has notified the facility of the intent of returning to it, the following apply:

(1) If the resident or their responsible party reserves their bed for a set number of days, the facility shall have written agreement for the payment for the days the bed is held in accordance with Rule .0704(a)(1)(A) of this Subchapter.

(2) If, after leaving the facility, the resident decides not to return to it, the facility shall require no more than a 14-day written notice that he or she is not returning.

(3) If the facility requires a 14-day written notice, the requirement shall be a part of the written agreement and explained by the facility to the resident and his or her family or responsible person before signing.

(4) When a resident or someone acting on his or her behalf notifies the facility that he or she will not be returning to the facility, the facility shall refund the remainder of any advance payment to the resident or his or her responsible person. The refund shall include the amount equal to the cost of care for the period covered by the agreement. The refund shall be made within 14 days after notification that the resident will not be returning to the facility.

(5) The facility shall not require payment from a resident that receives State County Special Assistance for more than 30 days unless the resident is actually residing in the facility or it is anticipated that he or she will return to the facility within 30 days.

(6) Exceptions to the 14-day notice, if required by the facility, are cases where returning to the facility would jeopardize the health or safety of the resident or others in the facility as certified by the

resident's physician or approved by the county department of social services, and in the case of the resident's death. In these cases, the facility shall provide a refund of any advance payment calculated beginning with the day the facility is notified. The facility shall provide the refund to the authorized representative with 14 days after the resident leaves the facility or within 30 days after the resident's death.

(f) If a resident dies, the administrator of his or her estate or the Clerk of Superior Court, when no administrator for his or her estate has been appointed, shall be given a refund equal to the cost of care for the month minus any nights spent in the facility during the month. This is to be done within 30 days after the resident's death.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; June 1, 1987; April 1, 1984;
Temporary Amendment Eff. January 1, 2001;
Temporary Amendment Expired October 13, 2001;
Amended Eff. July 1, 2005;
Readopted Eff. June 1, 2024.

SECTION .1200 – POLICIES, RECORDS AND REPORTS

10A NCAC 13G .1201 RESIDENT RECORDS

(a) The following shall be maintained on each resident in an orderly manner in the resident's record in the family care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services.

(1) FL-2 or MR-2 Forms and patient transfer form or hospital discharge summary, when applicable;
(2) Resident Register;
(3) receipt for the following as required in Rule .0704 of this Subchapter:
 (A) contract for services, accommodations and rates;
 (B) house rules as specified in Rule .0704(2) of this Subchapter;
 (C) Declaration of Residents' Rights (G.S. 131D-21);
 (D) home's grievance procedures; and
 (E) civil rights statement;
(4) resident assessment and care plan;
(5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter;
(6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation;
(7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and
(8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged.

When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Items (1), (4), (5), (6) and (7) above may be sent with the resident.

(b) A resident financial record providing an accurate accounting of the receipt and disbursement of the resident's personal funds, if handled by the facility according to Rule .1103 of this Subchapter, shall be maintained on each resident in an orderly manner in the facility and be readily available for review by representatives of the Division of Health Service Regulation and county departments of social services. When there is an approved cluster of licensed facilities, financial records may be kept in one location among the clustered facilities

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1987; April 1, 1984;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .1202 TRANSFER OF RESIDENT'S RECORDS

At the request of the resident or his responsible person, copies of all pertinent information shall be given to the administrator of the licensed home to which the resident moves. The FL-2 or MR-2 shall be provided unless:

(1) It was completed more than 90 days before the move; or

(2) There has been an apparent change in the mental or physical condition of the resident.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1984;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .1203 DISPOSAL OF RESIDENT'S RECORDS

After a resident has left a family care home or died, the resident's records shall be filed in the home for at least one year and then stored for at least two more years.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 1987; April 1, 1984;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .1204 REPORT OF ADMISSIONS AND DISCHARGES

History Note: Authority G.S. 131D-2; 143B-153;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1992;
Repealed Eff. July 1, 2005.

10A NCAC 13G .1205 POPULATION REPORT

History Note: Authority G.S. 131D-2; 143B-153; 143B-165; S.L. 2002-160;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1992; April 1, 1984;
Temporary Repeal Eff. September 1, 2003;
Repealed Eff. June 1, 2004.

10A NCAC 13G .1206 HEALTH CARE PERSONNEL REGISTRY

The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 131E-256; 143B-165;
Temporary Adoption Eff. January 1, 2000;
Eff. July 1, 2000;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .1207 MARKETING

A family care home may market provided:

(1) the name used is as it appears on the license;

(2) only the services and accommodations for which the home is licensed are used; and
(3) the home is classified by licensure status.

History Note: *Authority G.S. 131D-2.1; 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Readopted Eff. January 1, 2020.

10A NCAC 13G .1208 FACILITIES TO REPORT RESIDENT DEATHS

The facility shall report resident deaths to the Division of Health Service Regulation, in accordance with G.S. 131D-34.1.

History Note: *Authority G.S. 131D-2.4; 131D-2.16; 131D-34.1; 143B-165;*
Temporary Adoption Eff. May 1, 2001;
Eff. July 18, 2002;
Readopted Eff. October 1, 2022.

10A NCAC 13G .1209 DEATH REPORTING PROCEDURES

(a) Upon learning of a resident death as described in Paragraphs (b) and (c) of this Rule, a facility shall file a report in accordance with this Rule. A facility shall be deemed to have learned of a resident death when any facility staff obtains information that the death occurred.

(b) A written notice containing the information listed under Paragraph (d) of this Rule shall be made immediately for the following:

(1) a resident death occurring in an adult care home within seven days of the use of a physical restraint or physical hold on the resident; or
(2) a resident death occurring within 24 hours of the resident's transfer from the adult care home to a hospital, if the death occurred within seven days of physical restraint or physical hold of the resident.

(c) A written notice containing the information under Paragraph (d) of this Rule shall be made within three days of any death resulting from violence, accident, suicide or homicide.

(d) Written notice may be submitted in person or by telefacsimile or electronic mail. If the reporting facility does not have the capacity or capability to submit a written notice immediately, the information contained in the notice may be reported by telephone following the same time requirements under Subparagraphs (b) and (c) of this Rule until such time the written notice may be submitted. The notice shall include at least the following information:

(1) Reporting facility: Name, address, county, license number (if applicable), Medicare/Medicaid provider number (if applicable), facility administrator and telephone number, name and title of person preparing report, first person to learn of death and first staff to receive report of death, and date and time report prepared;
(2) Resident information: Name, Medicaid number (if applicable), date of birth, age, sex, race, primary admitting diagnoses, and date of most recent admission to an acute care hospital.
(3) Circumstances of death: place and address where resident died, date and time death was discovered, physical location decedent was found, cause of death (if known), whether or not decedent was restrained at the time of death or within 7 days of death and if so, a description of the type of restraint and its usage, and a description of events surrounding the death; and
(4) Other information: list of other authorities such as law enforcement or the County Department of Social Services that have been notified, have investigated or are in the process of investigating the death or events related to the death.

(e) The facility shall submit a written report, using a form pursuant to G.S. 131D-34.1(e). The facility shall provide, fully and accurately, all information sought on the form. If the facility is unable to obtain any information sought on the form, or if any such information is not yet available, the facility shall so explain on the form.

(f) In addition, the facility shall:

(1) Notify the Division of Health Service Regulation immediately whenever it has reason to believe that information provided may be erroneous, misleading, or otherwise unreliable;
(2) Submit to the Division of Health Service Regulation, immediately after it becomes available, any information required by this rule that was previously unavailable; and

(3) Provide, upon request by the Division of Health Service Regulation, other information the facility obtains regarding the death, including, but not limited to, death certificates, autopsy reports, and reports by other authorities.

(g) With regard to any resident death under circumstances described in G.S. 130A-383, a facility shall notify the appropriate law enforcement authorities so the medical examiner of the county in which the body is found may be notified. Documentation of such notification shall be maintained by the facility and be made available for review by the Division upon request.

(h) In deaths not under the jurisdiction of the medical examiner, the facility shall notify the decedent's next-of-kin, or other individual authorized according to G.S. 130A-398, that an autopsy may be requested as designated in G.S. 130A-389.

History Note: Authority G.S. 131D-2.16; 131D-34.1; 143B-165;
Temporary Adoption Eff. May 1, 2001;
Eff. July 18, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .1210 DEFINITIONS APPLICABLE TO DEATH REPORTING

The following definitions shall apply throughout this Section:

(1) "Accident" means an unexpected, unnatural or irregular event contributing to a resident's death and includes, but is not limited to, medication errors, falls, fractures, choking, elopement, exposure, poisoning, drowning, fire, burns, or thermal injury, electrocution, misuse of equipment, motor vehicle accidents, and natural disasters.

(2) "Immediately" means at once, at or near the present time, without delay.

(3) "Violence" means physical force exerted for the purpose of violating, damaging, abusing or injuring. or abusing another person.

History Note: Authority G.S. 131D-2.16; 131D-34.1; 143B-165;
Temporary Adoption Eff. May 1, 2001;
Eff. July 18, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .1211 WRITTEN POLICIES AND PROCEDURES

(a) A family care home shall develop written policies and procedures that comply with applicable rules of this Subchapter, on the following:

(1) ordering, receiving, storage, discontinuation, disposition, administration, including self-administration, and monitoring the resident's reaction to medications, as developed in consultation with a licensed health professional who is authorized to dispense or administer medications;
(2) use of alternatives to physical restraints and the care of residents who are physically restrained, as developed in consultation with a registered nurse;
(3) accident, fire safety and emergency procedures;
(4) infection control;
(5) refunds;
(6) missing resident;
(7) identification and supervision of wandering residents;
(8) management of physical aggression or assault by a resident;
(9) handling of resident grievances;
(10) visitation in the facility by guests; and
(11) smoking and alcohol use.

(b) In addition to other training and orientation requirements in this Subchapter, all staff shall be trained within 30 days of hire on the policies and procedures listed as Subparagraphs (3), (4), (6), (7), (8), (9), (10) and (11) in Paragraph (a) of this Rule.

(c) Policies and procedures on which staff have been trained shall be available within the facility to staff for their reference.

History Note: Authority 131D-2.16; 143B-165;
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .1212 RECORD OF STAFF QUALIFICATIONS

A family care home shall maintain records of staff qualifications required by the rules in Section .0400 of this Subchapter in the facility. When there is an approved cluster of licensed facilities, these records may be kept in one location among the clustered facilities.

History Note: Authority G.S. 131D-2.16; 143B-165;
Temporary Adoption Eff. July 1, 2004;
Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .1213 REPORTING OF ACCIDENTS AND INCIDENTS

(a) A family care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid.

(b) Notification as required in Paragraph (a) of this Rule shall be by a copy of the death report completed according to Rule .1208 of this Subchapter or a written report that shall provide the following information:

(1) resident's name;
(2) name of staff who discovered the accident or incident;
(3) name of the person preparing the report;
(4) how, when and where the accident or incident occurred;
(5) nature of the injury;
(6) what was done for the resident, including any follow-up care;
(7) time of notification or attempts at notification of the resident's responsible person or contact person as required in Paragraph (e) of this Rule; and
(8) signature of the administrator or administrator-in-charge.

(c) The report as required in Paragraph (b) of this Rule shall be submitted to the county department of social services by mail, telefacsimile, electronic mail, or in person within 48 hours of the initial discovery or knowledge by staff of the accident or incident.

(d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident.

(e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification:

(1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and
(2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter.

(f) When a resident is at risk that death or physical harm will occur as a result of physical violence by another person, the facility shall immediately report the situation to the local law enforcement authority.

(g) In the case of physical assault by a resident or whenever there is a risk that death or physical harm will occur due to the actions or behavior of a resident, the facility shall immediately:

(1) seek the assistance of the local law enforcement authority;

(2) provide additional supervision of the threatening resident to protect others from harm;
(3) seek any needed emergency medical treatment;
(4) make a referral to the Local Management Entity for Mental Health Services or mental health provider for emergency treatment of the threatening resident; and
(5) cooperate with assessment personnel assigned to the case by the Local Management Entity for Mental Health Services or mental health provider to enable them to provide their earliest possible assessment.

(h) The facility shall immediately report any assault resulting in harm to a resident or other person in the facility to the local law enforcement authority.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 16, 2019.

10A NCAC 13G .1214 AVAILABILITY OF CORRECTIVE ACTION AND SURVEY REPORTS

A family care home shall make available to residents and their families or responsible persons and to prospective residents and their families or responsible persons, upon request and in a location accessible to residents and visitors in the home the following:

(1) the most recent annual or biennial and subsequent facility survey reports issued by the Adult Care Licensure Section of the Division of Health Service Regulation;
(2) any other survey reports issued by the Adult Care Licensure Section of the Division of Health Service Regulation within the past 12 months; and
(3) corrective action reports issued by the county department of social services within the past 12 months.

History Note: Authority 131D-2.16; 143B-165;
Eff. July 1, 2005;
Readopted Eff. January 1, 2022.

SECTION .1300 - USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES

10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES (EFFECTIVE UNTIL MARCH 31, 2024)

(a) A family care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be:

(1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes;
(2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule;
(3) the least restrictive restraint that would provide safety;
(4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record.
(5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule;
(6) applied correctly according to the manufacturer's instructions and the physician's order; and
(7) used in conjunction with alternatives in an effort to reduce restraint use.

Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

(b) The facility shall ask the resident or resident's legal representative if the resident may be restrained based on an order from the resident's physician. The facility shall inform the resident or legal representative of the reason for the

request and the benefits of restraint use and the negative outcomes and alternatives to restraint use. The resident or the resident's legal representative may accept or refuse restraints based on the information provided. Documentation shall consist of a statement signed by the resident or the resident's legal representative indicating the signer has been informed, the signer's acceptance or refusal of restraint use and, if accepted, the type of restraint to be used and the medical indicators for restraint use.

Note: Potential negative outcomes of restraint use include incontinence, decreased range of motion, decreased ability to ambulate, increased risk of pressure ulcers, symptoms of withdrawal or depression and reduced social contact.

(c) In addition to the requirements in Rule 13F .0801, .0802 and .0903 of this Subchapter regarding assessments and care planning, the resident assessment and care planning prior to application of restraints as required in Subparagraph (a)(5) of this Rule shall meet the following requirements:

(1) The assessment and care planning shall be implemented through a team process with the team consisting of at least a staff supervisor or personal care aide, a registered nurse, the resident and the resident's responsible person or legal representative. If the resident or resident's responsible person or legal representative is unable to participate, there shall be documentation in the resident's record that they were notified and declined the invitation or were unable to attend.

(2) The assessment shall include consideration of the following:
- (A) medical symptoms that warrant the use of a restraint;
- (B) how the medical symptoms affect the resident;
- (C) when the medical symptoms were first observed;
- (D) how often the symptoms occur;
- (E) alternatives that have been provided and the resident's response; and
- (F) the least restrictive type of physical restraint that would provide safety.

(3) The care plan shall include the following:
- (A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained;
- (B) the type of restraint to be used; and
- (C) care to be provided to the resident during the time the resident is restrained.

(d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule:

(1) The order shall indicate:
- (A) the medical need for the restraint;
- (B) the type of restraint to be used;
- (C) the period of time the restraint is to be used; and
- (D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and two hours for releases.

(2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician of the order within seven days.

(3) The restraint order shall be updated by the resident's physician at least every three months following the initial order.

(4) If the resident's physician changes, the physician who is to attend the resident shall update and sign the existing order.

(5) In emergency situations, the administrator or administrator-in-charge shall make the determination relative to the need for a restraint and its type and duration of use until a physician is contacted. Contact with a physician shall be made within 24 hours and documented in the resident's record.

(6) The restraint order shall be kept in the resident’s record.

(e) All instances of the use of physical restraints and alternatives shall be documented by the facility in the resident's record and include the following:

(1) restraint alternatives that were provided and the resident's response;
(2) type of restraint that was used;
(3) medical symptoms warranting restraint use;
(4) the time the restraint was applied and the duration of restraint use;
(5) care that was provided to the resident during restraint use; and
(6) behavior of the resident during restraint use.

(f) Physical restraints shall be applied only by staff who have received training according to Rule .0506 of this Subchapter and been validated on restraint use according to Rule .0504 of this Subchapter.

History Note: Authority G.S. 131D-2.16; 143B-165;
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, 2005.

SECTION .1300 - USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES

10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES (EFFECTIVE APRIL 1, 2024)

(a) A family care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and that restricts freedom of movement or normal access to one's body, shall be:

(1) used only in those circumstances in which the resident has medical symptoms for which the resident's physician or physician extender has determined warrant the use of restraints and not for , discipline or convenience purposes;

(2) used only with a written order from a physician or physician extender except in emergencies where the health or safety of the resident is threatened, according to Paragraph (d) of this Rule;

(3) the least restrictive restraint that would provide a safe environment for the resident and prevent physical injury;

(4) used only after alternatives that would provide a safe environment for the resident to prevent physical injury and prevent a potential decline in the resident's functioning have been tried and documented by the administrator or their designee in the resident's record as being unsuccessful.

(5) used only after an assessment and care planning process has been completed, except in emergencies where the health or safety of the resident is threatened, according to Paragraph (c) of this Rule;

(6) applied correctly according to the manufacturer's instructions and the physician's or physician extenders' order; and

(7) used in conjunction with alternatives in an effort to reduce restraint use. For the purpose of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner.

Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

(b) The facility shall obtain written consent from the resident, the resident's responsible person, or legal representative for the resident to be restrained based on an order from the resident's physician or physician extender. The facility shall inform the resident, the resident's responsible person or legal representative of the reason for the request, the benefits of restraint use, and the negative outcomes and alternatives to restraint use. The resident or the resident's legal representative may accept or refuse restraints based on the information provided. Documentation shall consist of a statement signed by the resident or the resident's legal representative indicating the signer has been informed, the signer's acceptance or refusal of restraint use and, if accepted, the type of restraint to be used and the medical indicators for restraint use.

Note: Potential negative outcomes of restraint use include incontinence, decreased range of motion, decreased ability to ambulate, increased risk of pressure ulcers, symptoms of withdrawal or depression, and reduced social contact.

(c) In addition to the requirements in Rule .0801, .0802 and .0903 of this Subchapter regarding assessments and care planning, the resident assessment and care planning prior to application of restraints as required in Subparagraph (a)(5) of this Rule shall meet the following requirements:

(1) The assessment and care planning shall be implemented through a team process with the team consisting of at least a supervisor or personal care aide, a registered nurse, the resident and the resident's responsible person or legal representative. If the resident or resident's responsible person or legal representative is unable to participate, there shall be documentation in the resident's record that they were notified and declined the invitation or were unable to attend.

(2) The assessment shall include consideration of the following:

(A) medical symptoms that warrant the use of a restraint;

(B) how the medical symptoms affect the resident;
(C) when the medical symptoms were first observed;
(D) how often the symptoms occur;
(E) alternatives that have been provided and the resident's response; and
(F) the least restrictive type of physical restraint that would provide safety.

(3) The care plan shall include the following:
(A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained;
(B) the type of restraint to be used; and
(C) care to be provided to the resident during the time the resident is restrained.

(d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule:
(1) The order shall indicate:
(A) the medical need for the restraint based on the assessment and care plan;
(B) the type of restraint to be used;
(C) the period of time the restraint is to be used; and
(D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and no longer than two hours for releases.
(2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician or physician extender of the order within seven days.
(3) The restraint order shall be updated by the resident's physician or physician extender at least every three months following the initial order.
(4) If the resident's physician changes, the physician or physician extender who is to attend the resident shall update and sign the existing order.
(5) In an emergency, where the health or safety of the resident is threatened, the administrator or their designee shall make the determination relative to the need for a restraint and its type and duration of use until a physician or physician extender is contacted. Contact with a physician or physician extender shall be made within 24 hours and documented in the resident's record. For the purpose of this Rule, an "emergency" means a situation where there is a certain risk of physical injury or death to a resident.
(6) The restraint order shall be kept in the resident's record.

(e) All instances of the use of physical restraints and alternatives shall be documented by the facility in the resident's record and include the following:
(1) restraint alternatives that were provided and the resident's response;
(2) type of restraint that was used;
(3) medical symptoms warranting restraint use;
(4) the time the restraint was applied and the duration of restraint use;
(5) care that was provided to the resident during restraint use; and
(6) behavior of the resident during restraint use.

(f) Physical restraints shall be applied only by staff who have received training on the use of alternatives to physical restraint use and on the care of residents who are physically restrained according to Rule .0506 of this Subchapter and have been validated on the care of residents who are physically restrained and the use of care practices as alternatives to restraints according to Rule .0504 of this Subchapter.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, 2005;
Readopted Eff. April 1, 2024.

SECTION .1500 – ADMINISTRATOR APPROVAL AND RENEWAL

10A NCAC 13G .1501 ADMINISTRATOR APPROVAL

(a) Each family care home shall have an administrator that has been approved by the Department pursuant to this Rule.

(b) Applicant administrators shall meet the following qualifications:
(1) be 21 years of age or older;

(2) provide a satisfactory criminal background report by providing to the Department the submissions required by:
   (A) the State Repository of Criminal Histories, if the applicant has been a resident of this State for five years or more; or
   (B) both the State and National Repositories of Criminal Histories, if the applicant has been a resident of this State for less than five years;
(3) complete an approved administrator-in-training program listed on the website at https://info.ncdhhs.gov/dhsr/acls/adminguidelines.html and consisting of a minimum of 20 hours of instruction in N.C. Assisted Living laws and statutes, human resources, and business management, and a minimum of 100 hours of on-the-job training in an assisted living facility;
(4) complete with 75 percent accuracy a written examination administered by the Department within 12 months of completing the administrator-in-training program; and
(5) be at least a high school graduate or certified under the GED Program.

(c) For the purpose of this Rule, a satisfactory criminal background report means:
(1) no conviction by any jurisdiction of a felony for which prison time was served unless rights of citizenship have been restored and all of the following have been considered and determined by the Department to allow approval:
   (A) the date of conviction;
   (B) the circumstances surrounding the committing of the crime, if known;
   (C) the nexus between the criminal conduct of the person and job duties; and
   (D) the prison, jail, probation, parole, rehabilitation and employment records of the person since the date the crime was committed;
(2) no conviction by any jurisdiction of a misdemeanor unless all terms of the judgment imposed for said misdemeanor have been met and the following have been considered and determined by the Department to allow approval:
   (A) the date of conviction;
   (B) the circumstances surrounding the committing of the crime, if known;
   (C) the nexus between the criminal conduct of the person and job duties; and
   (D) the prison, jail, probation, parole, rehabilitation and employment records of the person since the date the crime was committed.

History Note: Authority G.S. 131D-2.16; 131D-4.3; 143B-165;
Eff. April 1, 2017;
Amended Eff. April 1, 2022.

10A NCAC 13G .1502 ADVERSE ACTION ON ADMINISTRATOR APPROVAL

(a) The Department shall deny, suspend, or revoke the approval of an administrator if the administrator or applicant administrator:
(1) has not completed the continuing education credits required by Rule .1503 of this Section;
(2) has been convicted by any jurisdiction of a felony unless rights of citizenship have been restored and all of the following have been considered and determined by the Department to allow approval:
   (A) the date of conviction;
   (B) the circumstances surrounding the committing of the crime, if known;
   (C) the nexus between the criminal conduct of the person and the duties of an administrator; and
   (D) the prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed;
(3) is convicted by any jurisdiction of a misdemeanor unless all terms of the judgment imposed for said misdemeanor have been met and the following have been considered and determined by the Department to allow approval:
   (A) the date of conviction;
   (B) the circumstances surrounding the committing of the crime, if known;
   (C) the nexus between the criminal conduct of the person and the duties of an administrator; and

(D) the prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed;

(4) was the administrator of an adult care home or family care home whose license was summarily suspended pursuant to G.S. 131D-2.7(c) or a notice of revocation of the facility's license was issued pursuant to G.S. 131D-2.7(b). In these circumstances, the Department shall take into consideration the length of time the administrator was serving in that capacity at the facility and the nexus between the reason for the summary suspension or revocation of the facility's license and the job duties of the administrator in deciding whether to deny, suspend, or revoke the approval of an administrator;

(5) is unable to perform as administrator with reasonable skill and safety to residents by reason of any observable or documented condition, such as dementia or other disease or condition known to result in irreversible cognitive deterioration or drug or alcohol dependency, that impairs the individual in such a way that it endangers the health, safety, or welfare of residents;

(6) tested positive for a controlled substance or refused to consent to drug testing according to G.S. 131D-45;

(7) prior or subsequent to applying to be an administrator, has a finding on the North Carolina Health Care Personnel Registry pursuant to G.S. 131E-256; or

(8) fails to report any arrest or conviction for a felony or misdemeanor to the Department within 10 days after such arrest or conviction.

(b) The Department shall suspend the approval of an administrator who has been arrested because of alleged criminal conduct, if the relationship between the alleged criminal conduct and the administrator's duties indicates a need to seek action in order to further protect facility residents pending adjudication by a court. Serving as an administrator while the administrator's approval is suspended shall be grounds for revocation of approval. Examples of criminal conduct the Department may consider in relation to the administrator's duties include fraud, physical assault, theft, abuse, neglect, exploitation, and drug diversion.

History Note: Authority G.S. 131D-2.16; 131D-2.18; 131D-4.3; 143B-165;
Eff. April 1, 2017.

10A NCAC 13G .1503 RENEWAL OF ADMINISTRATOR APPROVAL

(a) The Department shall renew an administrator's approval at the end of the year following the year of initial approval if the administrator submits documentation of completed coursework related to long term care management or the care of aged and disabled persons dated and issued by the course provider after approval. The required number of hours or coursework shall be prorated by the Department based 30 hours of required continuing education biennially and the number of months from the date of the administrator's initial approval until June 30 of the next year following issuance.

(b) The Department shall continue to renew an administrator's approval biennially based on an expiration date of June 30. For each renewal following initial renewal the administrator shall submit documentation totaling 30 hours of completed coursework related to long term care management or the care of aged and disabled persons dated and issued by the course provider within the current two-year approval period.

(c) For the purposes of this Rule, examples of coursework related to long term care management or the care of aged and disabled persons include financial management, human resource management, medication administration, dementia care, diabetic care, managing aggressive behaviors, and infection control.

History Note: Authority G.S. 131D-2.16; 131D-4.3; 143B-165;
Eff. April 1, 2017.

SECTION .1600 – STAR RATED CERTIFICATES

10A NCAC 13G .1601 DEFINITIONS

(a) As used in this Section, the following definitions shall apply:

(1) "Demerits" means points which are subtracted from a facility's star rating calculation as set forth in the requirements of Rule .1604 of this Section.

(2) "Merits" means points which are added to a facility's star rating calculation as set forth in the requirements of Rule .1604 of this Section.

(3) "Standard deficiency" means a citation issued by the Division of Health Service Regulation to a facility for failure to comply with licensure rules and statutes governing adult care homes and the non-compliance does not meet the criteria of a Type A1, Type A2 or Type B violation defined in G.S. 131D-34.
(4) "Star rated certificate" means a certificate issued by the Division of Health Service Regulation that includes a numerical score and corresponding number of stars issued to an adult care home based on the factors contained in G.S. 131D-10.
(5) "Star rating" means the numerical score and corresponding number of stars a facility receives based on the factors contained in G.S. 131D-10.
(6) "Star rating worksheet" means a document issued by the Division of Health Service Regulation which demonstrates how a facility's star rating was calculated in accordance with G.S. 131D-10(e) and Section .1600 of this Subchapter.
(7) "Type A1 violation" means the term as defined in G.S. 131D-34.
(8) "Type A2 violation" means the term as defined in G.S. 131D-34.
(9) "Type B violation" means the term as defined in G.S. 131D-34.

History Note: Authority G.S. 131D-4.5; 131D-10;
Eff. July 3, 2008;
Readopted Eff. August 1, 2025.

10A NCAC 13G .1602 ISSUANCE OF A STAR RATING

(a) A star rated certificate and worksheet shall be issued to a facility by the Division of Health Service Regulation within 45 days from the date that the Division mails the survey or inspection report to the facility, except when a request has been made by the facility under G.S. 131D-2.11 for informal dispute resolution. If a facility makes a request for informal dispute resolution, the Division of Health Service Regulation shall issue a star rating to the facility within 15 days from the date the Division mails the informal dispute decision to the facility.
(b) If the ownership of the facility changes, the star rating in effect at the time of the change of ownership shall remain in effect until the next annual or biennial survey or until a new certificate is issued pursuant to Rule .1604(b) of this Subchapter.
(c) The star rated certificate and worksheet the Division used to calculate the rating shall be displayed in a location visible to the public.
(d) The star rating worksheet shall be posted on the Division of Health Service Regulation website.
(e) The facility may contest the star rating by requesting a contested case hearing pursuant to Article 3 of G.S. 150B. The star rating and any subsequent star ratings shall remain in effect during any contested case hearing process.

History Note: Authority G.S. 131D-4.5; 131D-10;
Eff. July 3, 2008;
Readopted Eff. August 1, 2025.

10A NCAC 13G .1603 STATUTORY AND RULE REQUIREMENTS AFFECTING STAR RATED CERTIFICATES

The following Statutes and Rules comprise the standards that contribute to rated certificates:
(1) G.S. 131D-21 Declaration of Resident's Rights;
(2) Section .0300 of this Subchapter The Building;
(3) Section .0400 of this Subchapter Staff Qualifications;
(4) Section .0700 of this Subchapter Admission and Discharge;
(5) Section .0800 of this Subchapter Resident Assessment and Care Plan;
(6) Section .0900 of this Subchapter Resident Care and Services;
(7) Section .1000 of this Subchapter Medications;
(8) Section .1300 of this Subchapter Use of Physical Restraints and Alternatives; and
(9) Section .1700 of this Subchapter Infection Prevention and Control.

History Note: Authority G.S. 131D-4.5; 131D-10;
Eff. July 3, 2008;
Readopted Eff. August 1, 2025.

10A NCAC 13G .1604 RATING CALCULATION

(a) Ratings shall be based on:

(1) Inspections completed pursuant to G.S. 131D-2.11(a) and (a1);

(2) Statutory and Rule requirements listed in Rule .1603 of this Section;

(3) Type A1, Type A2, or uncorrected Type B penalty violations identified pursuant to G.S. 131D-34; and

(4) Other items listed in Subparagraphs (c)(1) and (c)(2) of this Rule.

(b) The initial rating a facility receives shall remain in effect until the next inspection. If an activity occurs which results in the assignment of additional merit or demerit points, a new certificate shall be issued pursuant to Rule .1602(a) of this Section.

(c) The rating shall be based on a 100 point scale. Beginning with the initial rating and repeating with each annual or biennial inspection, the facility shall be assigned 100 points and shall receive merits or demerits, which shall be added or subtracted from the 100 points, respectively. The merits and demerits shall be assigned as follows:

(1) Merit Points

(A) If the facility corrects a standard deficiency of noncompliance with the statutes or rules listed in Rule .1603 of this Subchapter, the facility shall receive 1.25 merit points for each corrected deficiency;

(B) If the facility corrects a citation for which a Type B violation was identified, the facility shall receive 1.75 merit points;

(C) If the facility corrects a previously uncorrected Type B violation, the facility shall receive 1.75 merit points;

(D) If the facility corrects the citation for which a Type A1 or Type A2 violation was identified, the facility shall receive 5 merit points;

(E) If the facility corrects a previously uncorrected Type A1 or A2 violation, the facility shall receive 5 merit points;

(F) If the facility's admissions have been suspended, the facility shall receive 5 merit points if the suspension is removed;

(G) If the facility's license is restored to a full license after being downgraded to a provisional license, the facility shall receive 5 merit points;

(H) If the facility participates in any quality improvement program pursuant to G.S. 131D-10, the facility shall receive 2.5 merit points;

(I) If the facility establishes an ongoing resident council which meets at least quarterly, the facility shall receive .5 merit point;

(J) If the facility establishes an ongoing family council which meets at least quarterly, the facility shall receive .5 merit point;

(K) If the facility's designated on-site staff member who directs the facility's infection control activities in accordance with G.S. 131D-4.4A has completed the "Infection Control in Long Term Care Facilities" course offered by the University of North Carolina Statewide Program for Infection Control and Epidemiology (SPICE) every two years, the facility shall receive .5 merit point;

(L) If the facility permanently installs a generator or has a contract with a generator provider to provide emergency power for essential functions of the facility, the facility shall receive 2 merit points. For purposes of this Rule, essential functions mean those functions necessary to maintain the health or safety of residents during power outages greater than 6 hours and include the fire alarm system, heating, lighting, refrigeration for medication storage, minimal cooking, elevators, medical equipment, computers, door alarms, special locking systems, sewage and well operation where applicable, sprinkler system, and telephones. If the facility has an existing permanently installed generator or an existing contract with a generator provider, the facility shall receive 1 merit point for maintaining the generator in working order or continuing the contract with a generator provider;

(M) If the facility installs automatic sprinklers in compliance with the North Carolina Building Code, and maintains the system in working order, the facility shall receive 3 merit points. If the facility has an existing automatic sprinkler, the facility shall receive 2 merit points for subsequent ratings for maintaining the automatic sprinklers in working order; and

(N) If the facility engages the services of a third-party company to conduct resident and family satisfaction surveys at least annually for the purpose of improving resident care, the facility shall receive 1 merit point. Resident and family satisfaction surveys shall not be conducted by any employees of the facility, or a third-party company affiliated with the facility. The satisfaction survey results shall be made available upon request and in a location accessible to residents and visitors in the facility.

(2) Demerit Points

(A) For each standard deficiency of noncompliance with the statutes or rules listed in Rule .1603 of this Subchapter, the facility shall receive a demerit of 2 points. The facility shall receive demerit points only once for citations in which the findings are identical to those findings used for another citation;

(B) For each citation of a Type A1 or Type A2 violation, the facility shall receive a demerit of 10 points, and if the Type A1 or Type A2 violation remains uncorrected as result of a follow-up inspection, the facility shall receive an additional demerit of 10 points;

(C) For each citation of a Type B violation, the facility shall receive a demerit of 3.5 points and if the Type B violation remains uncorrected as the result of a follow-up inspection, the facility shall receive an additional demerit of 3.5 points;

(D) If the facility's admissions are suspended, the facility shall receive a demerit of 10 points; however, if the facility's admissions are suspended pursuant to G.S. 131D-2.7, the facility shall not receive any demerit points;

(E) If the facility's license is downgraded to a provisional license pursuant to G.S. 131D-2.7, the facility shall receive a demerit of 10 points;

(F) If the facility receives a notice of revocation against its license pursuant to G.S. 131D-2.7, the facility shall receive a demerit of 31 points; and

(G) If the facility's license is summarily suspended pursuant to G.S. 131D-2.7, the facility shall receive a demerit of 31 points.

(d) Facilities shall be given a rating of zero to four stars depending on the score assigned pursuant to Paragraph (a), (b) or (c) of this Rule. Ratings shall be assigned as follows:

(1) Four stars shall be assigned to any facility whose score is 100 points or greater on two consecutive annual or biennial inspections;

(2) Three stars shall be assigned for scores of 90 to 99.9 points, or for any facility whose score is 100 points or greater on one annual or biennial inspection;

(3) Two stars shall be assigned for scores of 80 to 89.9 points;

(4) One star shall be assigned for scores of 70 to 79.9 points; and

(5) Zero stars shall be assigned for scores of 69.9 points or lower.

History Note: *Authority G.S. 131D-4.5; 131D-10;*
Eff. July 3, 2008;
Readopted Eff. August 1, 2025.

10A NCAC 13G .1605 CONTENTS OF STAR RATED CERTIFICATE

(a) The certificate shall contain a rating determined pursuant to Rule .1604 of this Subchapter.

(b) The certificate or accompanying worksheet from which the score is derived shall contain a breakdown of the point merits and demerits by the factors listed in Rules .1603 and .1604(c) of this Subchapter in a manner that the public can determine how the rating was assigned and the factors that contributed to the rating.

(c) The Division of Health Service Regulation shall issue the certificate pursuant to Rule .1602 of this Subchapter.

History Note: *Authority G.S. 131D-4.5; 131D-10;*
Eff. July 3, 2008;
Readopted Eff. August 1, 2025.

SECTION .1700 - INFECTION PREVENTION AND CONTROL

10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES

(a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement infection prevention and control policies and procedures consistent with the federal Centers for

Disease Control and Prevention (CDC) published guidelines on infection prevention and control. The Department shall approve a set of policies and procedures for infection prevention and control consistent with the federal CDC published guidelines on infection prevention and control that will be made available on the Division of Health Service Regulation, Adult Care Licensure Section website at https://info.ncdhhs.gov/dhsr/acls/acforms.html at no cost. The facility shall either:

(1) utilize the set of policies and procedures for infection prevention and control approved by the Department;

(2) develop policies and procedures for infection and prevention and control that are consistent with the set of Department approved policies and procedures; or

(3) develop policies and procedures for infection prevention and control that are based on nationally recognized standards in infection prevention and control that are consistent with the federal CDC published guidelines on infection prevention and control.

(b) The facility's infection and control policies and procedures shall be implemented by the facility and shall address the following:

(1) Standard and transmission-based precautions, including:

(A) respiratory hygiene and cough etiquette;

(B) environmental cleaning and disinfection;

(C) reprocessing and disinfection of reusable resident medical equipment;

(D) hand hygiene;

(E) accessibility and proper use of personal protective equipment (PPE); and

(F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions;

(2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1702 of this Section;

(3) Measures for the facility to consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents, and visitors for signs of illness; and use of source control as tolerated by the residents; and

(4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak.

(c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's infection prevention and control policies and procedures, and when issued, guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat that have been issued in writing by the North Carolina Department of Health and Human Services or local health department.

(d) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(4), the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs (b)(1) through (b)(2) of this Rule.

(e) The policies and procedures listed in Paragraph (b) of this Rule shall be maintained in the facility and accessible to staff working at the facility.

History Note: *Authority G.S. 131D-2.16; 131D-4.4A; 143B-165;*
Emergency Adoption Eff. October 23, 2020;
Temporary Adoption Eff. December 30, 2020;
Eff. August 23, 2022.

10A NCAC 13G .1702 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK

(a) The facility shall report suspected or confirmed communicable diseases and conditions within the time period and
in the manner determined by the Commission for Public Health as specified in 10A NCAC 41A .0101 and 10A NCAC 41A .0102(a)(1) through (a)(3), which are hereby incorporated by reference, including subsequent amendments.

(b) The facility shall provide the residents and their representative(s) and staff with an initial notice within 24 hours following confirmation by the local health department of a communicable disease outbreak. The facility, in its initial notification to residents and their representative(s), shall:

(1) not disclose any personally identifiable information of the residents or staff;

(2) provide information on the measures the facility is taking to prevent or reduce the risk of transmission, including whether normal operations of the facility will change; and

(3) provide information to the resident(s) concerning measures they can take to reduce the risk of spread or transmission of infection.

(c) Following the initial notice to residents and their representative(s) of a communicable disease outbreak, the facility shall provide the following:

(1) an update every two weeks until the communicable illness within the facility has resolved, as determined by the local health department; and

(2) an update that the communicable illness within the facility has resolved, as determined by the local health department.

History Note: Authority G.S. 131D-2.16; 131D-4.4B; 131D-4.5; 143B-165;
Emergency Adoption Eff. October 23, 2020;
Temporary Adoption Eff. December 30, 2020;
Eff. August 23, 2022.

SUBCHAPTER 13H - LICENSING OF HOMES FOR DEVELOPMENTALLY DISABLED ADULTS

SECTION .0100 - IDENTIFYING INFORMATION

10A NCAC 13H .0101 GROUP HOMES; DEVELOPMENTALLY DISABLED ADULTS
10A NCAC 13H .0102 GROUP HOMES FOR DEVELOPMENTALLY DISABLED ADULTS
10A NCAC 13H .0103 PRIVATE FOR PROFIT GROUP HOMES
10A NCAC 13H .0104 DEFINITIONS

History Note: Authority G.S. 131D-2; 143B-153; 168-1; 168-9;
Eff. January 1, 1978;
Amended Eff. July 1, 1990; February 1, 1986;
Repealed Eff. April 1, 2015.

SECTION .0200 - MANAGEMENT IN PRIVATE FOR PROFIT HOMES

10A NCAC 13H .0201 REGULATION
10A NCAC 13H .0202 THE CO-ADMINISTRATOR
10A NCAC 13H .0203 RELIEF PERSON-IN-CHARGE

History Note: Authority G.S. 131D-2; 143B-153; 168-1; 168-9;
Eff. January 1, 1978;
Amended Eff. April 1, 1987; November 1, 1984;
Repealed Eff. April 1, 2015.

SECTION .0300 - MANAGEMENT IN HOMES OPERATED BY PRIVATE NON-PROFIT BOARDS

10A NCAC 13H .0301 THE HOME MANAGER IN PRIVATE NON-PROFIT HOMES
10A NCAC 13H .0302 CHANGE OF MANAGER

History Note: Authority G.S. 131D-2; 143B-153; 168-1; 168-9;
Eff. January 1, 1978;
Amended Eff. July 1, 1990; April 1, 1987; November 1, 1984;
Repealed Eff. April 1, 2015.

SECTION .0400 - PERSONNEL

10A NCAC 13H .0401 PERSONNEL REQUIREMENTS
10A NCAC 13H .0402 QUALIFICATIONS OF OTHER STAFF AND FAMILY MEMBERS LIVING IN
10A NCAC 13H .0403 QUALIFICATIONS OF RELIEF PERSON-IN-CHARGE
10A NCAC 13H .0404 RESPONSIBILITIES OF RELIEF PERON-IN-CHARGE
10A NCAC 13H .0405 QUALIFICATIONS OF OTHER STAFF NOT LIVING IN
10A NACA 13H .0406 HEALTH REQUIREMENTS
10A NACA 13H .0407 GENERAL PERSONNEL REQUIREMENTS

History Note: Authority G.S. 131D-2; 131D-4.5; 143B-153; 168-1; 168-9; S.L. 99-0334;
Eff. January 1, 1978;
Amended Eff. July 1, 1990; September 1, 1987; April 1, 1987; February 1, 1986; November 1, 1984; AARC Objection Lodged January 1, 1991;
Amended Eff. May 1, 1992; August 1, 1991;
Temporary Amendment Eff. January 1, 2000; December 1, 1999;
Amended Eff. July 1, 2000;
Repealed Eff. April 1, 2015.

10A NCAC 13H .0408 STAFF COMPETENCY AND TRAINING
10A NCAC 13H .0409 TRAINING PROGRAM CONTENT AND APPROVAL

History Note: Authority G.S. 131D-2; 131D-4.3; 143B-153;
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Repealed Eff. April 1, 2015.

10A NCAC 13H .0410 QUALIFICATIONS OF MEDICATION STAFF
10A NCAC 13H .0411 MEDICATION ADMINISTRATION COMPETENCY EVALUATION

History Note: Authority G.S. 131D-2; 131D-4.5; 143B-165; S.L. 1999-0334;
Temporary Adoption Eff. January 1, 2000; December 1, 1999;
Eff. July 1, 2000;
Repealed Eff. April 1, 2015.

SECTION .0500 – THE HOME

10A NCAC 13H .0501 LOCATION
10A NCAC 13H .0502 CONSTRUCTION

History Note: Authority G.S. 131D-2; 143B-153; 168-1; 168-9;
Eff. January 1, 1978;
Amended Eff. March 1, 1991; February 1, 1986;
Repealed Eff. April 1, 2015.

SECTION .0600 - ARRANGEMENT AND SIZE OF ROOMS

10A NCAC 13H .0601 LIVING AREAS
10A NCAC 13H .0602 DINING AREA
10A NCAC 13H .0603 KITCHEN
10A NCAC 13H .0604 BEDROOMS
10A NCAC 13H .0605 CLOSETS
10A NCAC 13H .0606 BATHROOMS
10A NCAC 13H .0607 STORAGE AREAS
10A NCAC 13H .0608 FLOORS

10A NCAC 13H .0609 LAUNDRY
10A NCAC 13H .0610 OUTSIDE ENTRANCES
10A NCAC 13H .0611 FIRE SAFETY REQUIREMENTS
10A NCAC 13H .0612 OTHER REQUIREMENTS
10A NCAC 13H .0613 HOUSEKEEPING AND FURNISHINGS

History Note: Authority G.S. 131D-2; 131D-4.5;143B-153; 143B-165;168-1; 168-9; S.L. 1999-0334;
Eff. January 1, 1978;
Amended Eff. July 1, 1982;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Repealed Eff. April 1, 2015.

SECTION .0700 - SERVICES

10A NCAC 13H .0701 PERSONAL CARE
10A NCAC 13H .0702 HEALTH CARE
10A NCAC 13H .0703 FOOD SERVICE
10A NCAC 13H .0704 OTHER REGULATIONS

History Note: Authority G.S. 131D-2; 143B-153; 168-1; 168-9;
Eff. January 1, 1978;
Repealed Eff. April 1, 2015.

SECTION .0800 - PROGRAM STANDARDS

10A NCAC 13H .0801 INDIVIDUAL GOALS
10A NCAC 13H .0802 INDIVIDUAL RECORDS
10A NCAC 13H .0803 POLICIES AND PROCEDURES
10A NCAC 13H .0804 RESIDENT'S LIVING STATUS
10A NCAC 13H .0805 ACTIVITIES OUTSIDE THE HOME
10A NCAC 13H .0806 ACCIDENT PREVENTION
10A NCAC 13H .0807 PLAN FOR MEDICAL SERVICES
10A NCAC 13H .0808 PERSONAL SKILLS DEVELOPMENT

History Note: Authority G.S. 131D-2; 143B-153; 168-1; 168-9;
Eff. January 1, 1978;
Amended Eff. February 1, 1986;
Repealed Eff. April 1, 2015.

SECTION .0900 - ADMISSION: TRANSFER: AND DISCHARGE POLICIES

10A NCAC 13H .0901 ADMISSIONS
10A NCAC 13H .0902 MEDICAL REQUIREMENTS
10A NCAC 13H .0903 PERSONAL INFORMATION
10A NCAC 13H .0904 WRITTEN AGREEMENTS
10A NCAC 13H .0905 PLANS AT TIME OF ADMISSION
10A NCAC 13H .0906 PROCEDURES FOR TRANSFER
10A NCAC 13H .0907 PROCEDURES FOR DISCHARGE

History Note: Authority G.S. 131D-2; 131D-4.5; 143B-153; 143B-165; 168-1; 168-9; S.L. 1999-0334;
Eff. January 1, 1978;
Amended Eff. July 1, 1990;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Repealed Eff. April 1, 2015.

SECTION .1000 - MEDICAL POLICIES

10A NCAC 13H .1001 PHYSICIANS
10A NCAC 13H .1002 PHYSICAL EXAMINATIONS
10A NCAC 13H .1003 MEDICATIONS

History Note: Authority G.S. 131D-2; 131D-4.5; 143B-153; 143B-165; 168-1; 168-9; S.L. 1999-0334;
Eff. January 1, 1978;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Repealed Eff. April 1, 2015.

SECTION .1100 – RATES: RESIDENTS' FUNDS: REFUNDS

10A NCAC 13H .1101 HANDLING FUNDS OF RESIDENTS
10A NCAC 13H .1102 REFUND POLICIES

History Note: Authority G.S. 131D-2; 143B-153; 168-1; 168-9;
Eff. January 1, 1978;
Amended Eff. July 1, 1990; February 1, 1986;
Repealed Eff. April 1, 2015.

SECTION .1200 - RECORDS AND REPORTS

10A NCAC 13H .1201 RECORDS
10A NCAC 13H .1202 REPORTS

History Note: Authority G.S. 131D-2; 143B-153; 168-1; 168-9;
Eff. January 1, 1978;
Repealed Eff. April 1, 2015.

SECTION .1300 - CAPACITY

10A NCAC 13H .1301 CAPACITY
10A NCAC 13H .1302 INCREASE IN CAPACITY

History Note: Authority G.S. 131D-2; 143B-153; 168-1; 168-9;
Eff. January 1, 1978;
Amended Eff. July 1990;
Repealed Eff. April 1, 2015.

SECTION .1400 - APPLICATION PROCEDURES

10A NCAC 13H .1401 APPLICATION FOR LICENSE
10A NCAC 13H .1402 NEW CONSTRUCTION: ADDITIONS AND RENOVATIONS

History Note: Authority G.S. 131D-2; 143B-153; 168-1; 168-9;
Eff. January 1, 1978;
Amended Eff. February 1, 1986;
Repealed Eff. April 1, 2015.

SECTION .1500 - LICENSING INFORMATION

10A NCAC 13H .1501 CURRENT LICENSE
10A NCAC 13H .1502 RENEWAL OF LICENSE

10A NCAC 13H .1503 TERMINATION OF LICENSE
10A NCAC 13H .1504 DENIAL OR REVOCATION OF LICENSE
10A NCAC 13H .1505 PROCEDURES FOR APPEAL

History Note: Authority G.S. 131D-2; 143B-153; 168-1; 168-9;
Eff. January 1, 1978;
Repealed Eff. April 1, 2015.

10A NCAC 13H .1506 SUSPENSION OF ADMISSIONS

History Note: Authority G.S. 130-9.7(e);
Eff. January 1, 1982;
Repealed Eff. April 1, 2015.

SECTION .1600 -MISCELLANEOUS RULES

10A NCAC 13H .1601 ADMINISTRATIVE PENALTY DETERMINATION PROCESS

History Note: Authority G.S. 131D-2; 131D-34; 143B-153;
Eff. December 1, 1993;
Repealed Eff. April 1, 2015.

10A NCAC 13H .1602 RESIDENT ASSESSMENT
10A NCAC 13H .1603 RESIDENT CARE PLAN
10A NCAC 13H .1604 LICENSED HEALTH PROFESSIONAL SUPPORT
10A NCAC 13H .1605 COOPERATION WITH CASE MANAGERS

History Note: Authority G.S. 131D-2; 131D-4.3; 143B-153;
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Repealed Eff. April 1, 2015.

10A NCAC 13H .1606 HEALTH CARE PERSONNEL REGISTRY

History Note: Authority G.S. 131D-2; 131D-4.5; 131E-256; 143B-165; S.L. 1999-0334;
Temporary Adoption Eff. January 1, 2000;
Eff. July 1, 2000;
Repealed Eff. April 1, 2015.

10A NCAC 13H .1607 RESPITE CARE

History Note: Authority G.S. 131D-2; 143B-165; S.L. 2000-50;
Temporary Adoption Eff. November 1, 2000;
Eff. July 18, 2002;
Repealed Eff. April 1, 2015.

SECTION .1700 – ADULT HOME CARE LICENSES

10A NCAC 13H .1701 DEFINITIONS
10A NCAC 13H .1702 PERSONS NOT ELIGIBLE FOR NEW ADULT CARE HOME LICENSES
10A NCAC 13H .1703 CONDITIONS FOR LICENSE RENEWAL

History Note: Authority G.S. 131D-2; 131D-4.5; 143B-165; S.L. 1999-0113; S.L. 1999-0334;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Repealed Eff. April 1, 2015.

SECTION .1800 – RESERVED FOR FUTURE CODIFICATION

SECTION .1900 – DEATH REPORTING REQUIREMENTS

10A NCAC 13H .1901 DEFINITIONS
10A NCAC 13H .1902 SCOPE
10A NCAC 13H .1903 REPORTING REQUIREMENTS

History Note: Authority G.S. 131D-2; 131D-34.1;
Temporary Adoption Eff. May 1, 2001;
Eff. July 18, 2002;
Repealed Eff. April 1, 2015.

SUBCHAPTER 13I – RESERVED FOR FUTURE CODIFICATION

SUBCHAPTER 13J – THE LICENSING OF HOME CARE AGENCIES

SECTION .0100 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13J .0100 RESERVED FOR FUTURE CODIFICATION

SECTION .0200 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13J .0200 RESERVED FOR FUTURE CODIFICATION

SECTION .0300 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13J .0300 RESERVED FOR FUTURE CODIFICATION

SECTION .0400 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13J .0400 RESERVED FOR FUTURE CODIFICATION

SECTION .0500 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13J .0500 RESERVED FOR FUTURE CODIFICATION

SECTION .0600 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13J .0600 RESERVED FOR FUTURE CODIFICATION

SECTION .0700 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13J .0700 RESERVED FOR FUTURE CODIFICATION

SECTION .0800 – RESERVED FOR FUTURE CODIFICATION

10A NCAC 13J .0800 RESERVED FOR FUTURE CODIFICATION

SECTION .0900 - GENERAL

10A NCAC 13J .0901 DEFINITIONS

Terms used in this Subchapter have the meanings as defined in G.S. 131E-136 and as follows:

(1) "Activities of Daily Living" (ADL) means mobility, eating, bathing, dressing, and toileting.

(2) "Agency" means a home care agency.

(3) "Agency director" means the person having administrative responsibility for the operation of the agency.

(4) "Client" means as defined in G.S. 131E-136 (2b).

(5) "Clinical respiratory services" means the provision of respiratory equipment and services that involve the assessment of a client's pulmonary status, monitoring of a client's response to therapy, and reporting to the client's physician. Procedures include: oximetry, blood gases, delivery of medication via aerosolization, management of ventilatory support equipment, pulmonary function testing, and infant monitoring.

(6) "Department" means the North Carolina Department of Health and Human Services.

(7) "Extensive Assistance" means a client is totally dependent or requires hands on assistance more than half the time while performing part of an activity, and meets one of the following criteria:

  (a) requires extensive assistance in more than two activities of daily living (ADLs), as defined in Item (1) of this Rule;

  (b) needs an in-home aide to perform at least one task at the nurse aide II level; or

  (c) requires extensive assistance in more than one ADL and has a medical or cognitive impairment as defined in Item (19) of this Rule.

(8) "Follow-up care" means services provided to a licensed hospital's discharged client in their home by a hospital's employees. No services shall exceed three visits in any two month period and shall not extend beyond a 12 month period following discharge, except pulmonary care, pulmonary rehabilitation, or ventilator services.

(9) "Governing body" means the person or group of persons having legal authority for the operation of the agency.

(10) "Hands-on care" means any home care service that involves touching the patient in order to implement the patient's plan of care.

(11) "Health care practitioner" means as defined in G.S. 90-640(a).

(12) "Infusion nursing services" means those services related to the administration of pharmaceutical agents into a body organ or cavity. Routes of administration include sub-cutaneous intravenous, intraspinal, epidural, or intrathecal infusion. Administration shall be by or under the supervision of a registered nurse in accordance with their legal scope of practice.

(13) "In-home aide services" are hands-on services that assist individuals, their family, or both with home management tasks, personal care tasks, or supervision of the client's activities to enable the individual, their family, or both to remain and function at home.

(14) "In-home caregiver" means any individual who provides home care services as enumerated in G.S. 131E-136.

(15) "Instrumental Activities of Daily Living" (IADL) means meal preparation, housekeeping, medication reminders, shopping, errands, transportation, money management, phone use, reading, and writing.

(16) "Licensed Clinical Social Worker" means as defined in G.S. 90B-3(6a).

(17) "Licensed practical nurse" means as defined in G.S. 90-171.30 or G.S 90-171.32.

(18) "Limited Assistance" means care to a client who requires hands-on care involving guided maneuvering of limbs with eating, toileting, bathing, dressing, personal hygiene, self-monitoring of medications, or other tasks assigned that require hands on assistance half the time or less during the activity and does not meet the definition of extensive assistance.

(19) "Medical or cognitive impairment" means a diagnosis and client assessment that documents at least one of the following:

  (a) pain that is present more than half the time that interferes with an individual's activity or movement;

  (b) dyspneic or short of breath with minimal exertion during the performance of ADLs and requires continuous use of oxygen; or

  (c) individual is not alert and oriented or is unable to shift attention and recall directions more than half the time.

(20) "Nursing registry" means a person or organization that maintains a list of nurses, in-home aides, or both that is made available to persons seeking nursing care or in-home aide service, but does not

collect a placement fee from the worker or client, coordinate the delivery of services, or supervise or control the provision of services.

(21) "Nursing services" means professional services provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse.

(22) "Occupational therapist" means as defined in G.S. 90-270.67(2) or G.S. 90-270.72.

(23) "Occupational therapist assistant" means as defined in G.S. 90-270.67(3) or G.S. 90-270.72.

(24) "Occupational therapy" means as defined in G.S. 90-270.67(4).

(25) "On-call services" means unscheduled home care services made available to clients on a 24-hour basis.

(26) "Personal care" means assistance to an individual with ADL and medical monitoring.

(27) "Physical therapist" means as defined in G.S. 90-270-24(2), G.S. 90-270-30, or G.S. 90-270-31(b).

(28) "Physical therapist assistant" means as defined in G.S. 90-270.24(3) or G.S. 90-270-31(b).

(29) "Physical therapy" means as defined in G.S. 90-270.24(4).

(30) "Physician" means as defined in G.S.90-9.1 or G.S. 90-9.2.

(31) "Plan of care" means the written description of the authorized home care services and tasks to be provided to a client.

(32) "Practice of respiratory care" means as defined in G.S.90-648(10).

(33) "Premises" means the location or licensed site that the agency provides home care services or maintains client service records or advertises itself as a home care agency.

(34) "Qualified" means suitable for employment as a consequence of having met the standards of education, experience, licensure, or certification established in the applicable job description created and adopted by the agency.

(35) "Registered nurse" means as defined in G.S. 90-171.30 or G.S. 90.171.32.

(36) "Respiratory care practitioner" means as defined in G.S. 90-648(12).

(37) "Scope of services" means those specific services provided by a licensed agency as listed on their home care license.

(38) "Survey" means an inspection by the Division of Health Service Regulation in order to assess the compliance of agencies with the home care licensure rules.

(39) "Social worker" means as defined in G.S 90B-3(8).

(40) "Speech and language pathologist" means as defined in G.S. 90-293(5).

(41) "Skilled Services" means all home care services enumerated in G.S. 131E-136(3) with the exception of in-home aide services.

(42) "The practice of speech and language pathology" means as defined in G.S. 90-293(7).

History Note: *Authority G.S. 131E-136; 131E-140;*
Eff. July 1, 1992;
RRC Objection due to lack of statutory authority Eff. November 16, 1995;
Amended Eff. January 1, 2010; February 1, 1996;
Readopted Eff. June 1, 2018.

10A NCAC 13J .0902 LICENSE

Each agency premises shall obtain a license unless exempted by G.S. 131E-136(3).

History Note: *Authority G.S. 131E-140;*
Eff. July 1, 1992;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .0903 APPLICATION FOR AND ISSUANCE OF LICENSE

(a) An application for the operation of an agency premises shall be submitted to the Department prior to the scheduling of an initial licensure survey or the issuance of a license. The agency shall establish, maintain and make available for inspection such documents, records and policies as required in this Section and statistical data sufficient to complete the licensure application and upon request of the Department, to submit an annual data report, as noted in Rule .1002(b) of this Subchapter. If the applicant cannot demonstrate to the Division of Health Service Regulation that he or she has ever owned or operated a home care agency prior to submission of the application, the

Division shall not issue a license until the applicant has received training approved by the Division which shall include the requirements for licensure, the licensure process, and the rules pertaining to the operation of a home care agency.
(b) The Department shall issue a license to each agency premises. Initial and ongoing licensure inspections may include all premises of an agency. Licensure shall be for a period of one year. Each license shall expire at midnight on the expiration date on the license and is renewable upon application.
(c) The license shall be posted in a prominent location accessible to public view within the premises. The agency shall also post a sign at the public access door with the agency name.
(d) The license shall be issued for the premises and persons named in the application and shall not be transferable. The name and street address under which the agency operates shall appear on the license. The license shall reflect the services provided by the agency.
(e) Prior to change of ownership or the establishment of a new agency, the agency must be in compliance with all the applicable statutes and rules. If the agency is authorized to provide Medicare certified Home Health Services, it shall also be in compliance with statutes and rules established under G.S. 131E, Article 9.
(f) The licensee shall notify the Department in writing of any proposed change in ownership or name at least 30 days prior to the effective date of the change.
(g) Any agency adding a new service category as outlined in G.S. 131E-136(3)(a) through (f) shall notify the Department in writing at least 30 days prior to the provision of that service to any clients. The Department shall approve the added service upon determining the agency is in compliance with the rules specific to the service being provided as contained in Section .1100 of this Subchapter.
(h) An agency shall notify the Department in writing if it discontinues or is unable to provide for a period of six continuous months any service category as outlined in G.S. 131E-136(3)(a) through (f) that is listed on the agency's license.

History Note: *Authority G.S. 131E-140;*
Eff. July 1, 1992;
Amended Eff. February 1, 1996; May 1, 1993;
Temporary Amendment Eff. April 1, 2006;
Amended Eff. November 1, 2006;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .0904 INSPECTIONS
(a) Any agency licensed by the Department shall be subject to proper inspections by authorized representatives of the Department at any time as a condition of holding such license.
(b) Any organization subject to licensure which presents itself to the public as a home care agency, which does not hold a license, and is or may be in violation of Rule .0902 of this Section and G.S. 131E-138 shall be subject to inspections at any time by authorized representatives of the Department.
(c) Authorized representatives of the Department shall make their identities known to the person in charge prior to inspection.
(d) Inspection of service records shall be carried out in accordance with G.S. 131E-141(b).
(e) An inspection shall be considered proper whenever the purpose of the inspection is to determine whether the agency complies with the provisions of this Subchapter or whenever there is reason to believe that some condition exists which is not in compliance with the rules in this Subchapter. The agency shall allow immediate access to its premises and the records necessary to conduct an inspection and determine compliance with the rules of this Subchapter. Failure to do so shall result in termination of the survey and may result in injunctive relief as outlined in G.S. 131E-142(b).
(f) An agency shall file a plan of correction for cited deficiencies within 10 working days of receipt. The Department shall review and respond to a written plan of correction within 10 working days of receipt.
(g) Representatives of the Department may visit clients in their homes to assess the agency's compliance with the clients' plans of care and with the licensure rules. Clients will be contacted by the agency staff in the presence of Department staff for permission to visit.

History Note: *Authority G.S. 131E-140;*
Eff. July 1, 1992;
Amended Eff. February 1, 1996;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .0905 MULTIPLE PREMISES

If a person operates multiple agency premises:

(1) the Department may conduct inspections at any or all of the premises and may issue a license to each of the premises based upon a sample inspection of any of the premises;

(2) with 72 hours advance notice, the Department may request records from any of the premises necessary to ensure compliance with the rules of this Subchapter be brought to the site being inspected, including the portions of personnel records subject to review. For agencies for whom a business or government policy precludes the disclosure of employee evaluations, a statement signed by the employee's supervisor attesting to its completion shall be accepted.

(3) the premises may share hands-on care staff or administrative staff, and may centralize the maintenance of records.

History Note: Authority G.S. 131E-140;
Eff. July 1, 1992;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .0906 COMPLIANCE WITH LAWS

(a) The agency shall be in compliance with all applicable federal, state, and local laws, rules, and regulations including Title XI Part A Section 1128B of the Social Security Act - Criminal penalties for acts involving Federal health care programs. A failure to comply with Federal law may subject the agency to civil or criminal penalties as set forth in 42 U.S.C. §1320a-7a - Making or causing to be made false statements or representations - and 42 U.S.C. §1320a-7b - Illegal remunerations.

(b) Staff of the agency shall be currently licensed or registered in accordance with applicable laws of the State of North Carolina.

(c) Nothing in this Rule shall prohibit the Department from conducting inspections as provided for in Rule .0904 of this Section.

(d) Any agency deemed to be in compliance by virtue of accreditation by one of the specified accrediting bodies listed in G.S. 131E-138(g) shall submit to the Department a copy of its accreditation report within 30 days after the agency receives its report each time it is surveyed by the accrediting body. The agency shall notify the Department of any action taken that affects its accreditation status, either temporarily or permanently. The Department may conduct annual validation surveys to assure compliance.

History Note: Authority G.S. 131E-138; 131E-140;
Eff. July 1, 1992;
Amended Eff. October 1, 2006; February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .0907 ADVERSE ACTION

(a) An agency may appeal any adverse decision made by the Department concerning its license by making such appeal in accordance with the Administrative Procedure Act, G.S. 150B and departmental rules 10A NCAC 01 et seq.

(b) The Department may amend a license by reducing it from a full license to a provisional license whenever the Department finds that:

(1) the licensee has substantially failed to comply with the provisions of G.S. 131E, Part C of Article 6 and the rules promulgated under that Part; and

(2) there is a reasonable probability that the licensee can remedy the licensure deficiencies within a reasonable length of time; and

(3) there is a reasonable probability that the licensee will be able thereafter to remain in compliance with the home care licensure rules for the foreseeable future.

The Department shall give the licensee written notice of the amendment of its license. This notice shall be given by registered or certified mail or by personal service and shall set forth the reasons for the action.
(c) The provisional license shall be effective immediately upon its receipt by the licensee and must be posted in a prominent location, accessible to public view, within the licensed premises in lieu of the full license. The provisional license shall remain in effect until:
(1) the Department restores the licensee to full licensure status; or
(2) the Department revokes the licensee's license; or
(3) the end of the licensee's licensure year. If a licensee has a provisional license at the time that the licensee submits a renewal application, the license, if renewed, shall also be a provisional license unless the Department determines that the licensee can be returned to full license status. A decision to issue a provisional license is stayed during the pendency of an administrative appeal and the licensee may continue to display its full license during the appeal.
(d) The Department may revoke a license whenever:
(1) The Department finds that:
(A) the licensee has substantially failed to comply with the provisions of G.S. 131E, Part C of Article 6 and the rules promulgated under those parts; and
(B) it is not reasonably probable that the licensee can remedy the licensure deficiencies within a reasonable length of time; or
(2) The Department finds that:
(A) the licensee has substantially failed to comply with the provisions of G.S. 131E, Part C of Article 6; and
(B) although the licensee may be able to remedy the deficiencies within a reasonable time, it is not reasonably probable that the licensee will be able to remain in compliance with the home care licensure rules for the foreseeable future; or
(3) The Department finds that there has been any failure to comply with the provisions of G.S. 131E, Part C of Article 6 and the rules promulgated under those parts that endangers the health, safety or welfare of the clients receiving services from the agency.
The issuance of a provisional license is not a procedural prerequisite to the revocation of a license pursuant to Subparagraphs (d)(1)(2) and (3) of this Rule.

History Note: *Authority G.S. 131E-140;*
Eff. July 1, 1992;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

SECTION .1000 - ADMINISTRATION

10A NCAC 13J .1001 AGENCY MANAGEMENT AND SUPERVISION
(a) The governing body or its designee shall establish and implement written policies governing agency operation. Such policies shall be available for inspection by the Department. The policies shall include:
(1) a description of the scope of services offered;
(2) admission and discharge policies;
(3) supervision of personnel;
(4) development of, and updates to, the plan of care;
(5) management of emergency care situations in the home;
(6) time frame for completion and return of service records to the agency;
(7) personnel qualifications;
(8) an organizational chart;
(9) program evaluation;
(10) employee and client confidentiality; and
(11) coordination of and referral to and from other community agencies and resources.
(b) The agency shall designate an individual to serve as agency director. The agency director shall have the authority and responsibility for administrative direction of the agency and shall meet one or more of the following qualifications:
(1) a health care practitioner as defined in G.S. 90-640(a);

(2) an individual who has at least two years of supervisory or management experience in home care or any other provider licensed pursuant to G.S. 131E or G.S. 122C; or
(3) an individual who holds a bachelor's degree in health, business or public administration science and has at least one year of supervisory or management experience in home care or other licensed health care program.

Such qualifications do not apply with respect to persons acting in the capacity of agency director prior to October 1, 2006.

(c) The agency shall designate a person responsible for supervising each type of home care service contained in Section .1100 of this Subchapter that is provided by the agency either directly or by contract. This individual may be the supervisor for one or more home care services and may also serve as the agency director.

(d) There shall be written documentation that specifies the responsibilities and authority of the agency director and supervisor.

(e) If the position of agency director becomes vacant, the Department shall be notified within five working days in writing of such vacancy along with the name of the replacement, if available. Agency policies shall define the order of authority in the absence of the administrator.

(f) The agency shall have the ultimate responsibility for the services provided under its license; however, it may make arrangements with contractors and others to provide services in accordance with Rule .1111 of this Subchapter.

(g) An agency shall have written policies which identify the specific geographic area in which the agency provides each service. If an agency plans to expand its geographic service area without opening an additional site, the Department shall be notified in writing 30 days in advance.

History Note: Authority G.S. 131E-140;
Eff. July 1, 1992;
Amended Eff. October 1, 2006; February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .1002 ADMINISTRATIVE, FINANCIAL AND STATISTICAL RECORDS

(a) The agency shall establish, maintain and make available for inspection the home care annual budget.

(b) The agency shall record, maintain and make available as requested to the Department statistical records. The records shall include the following:

(1) Number of home care staff, and their full-time equivalents including administrative, clerical, professional and paraprofessional and their total number of units of services;
(2) Client demographics, including county of residence and age;
(3) Number of units of service by applicable service category; and
(4) Total charges and number of visits by payor source (for Medicare certified agencies).

(c) Records shall be retained for a period of not less than three years.

(d) When an agency operates as a part of a health care facility licensed under Article 5 or 6 of G.S. 131E, or as a part of a larger diversified agency, records of home care activities and expenditures that are separate and identifiable shall be maintained for the agency.

History Note: Authority G.S. 131E-140;
Eff. July 1, 1992;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .1003 PERSONNEL

(a) Written policies shall be established and implemented by the agency regarding infection control and exposure to communicable diseases consistent with Subchapter 19A of Title 15A, North Carolina Administrative Code. These policies shall include provisions for compliance with 29 CFR 1910 (Occupational Safety and Health Standards) which is incorporated by reference including subsequent amendments. Copies of Title 29 Part 1910 can be purchased from the Superintendent of Documents, U.S. Government Printing Office, P.O. Box 371954, Pittsburgh, PA 15250-7954 or by calling Washington, D.C. (202) 512-1800. The cost is twenty-one dollars ($21.00) and may be purchased with a credit card.

(b) Hands-on care employees must have a baseline skin test for TB. Individuals who test positive must demonstrate noninfectious status prior to assignment in a client's home. Individuals who have previously tested positive to the TB skin test shall obtain a baseline and subsequent annual verification that they are free of TB symptoms. This verification shall be obtained from the local health department, a private physician or health nurse employed by the agency. The Tuberculosis Control Branch of the North Carolina Department of Health and Human Services, Division of Public Health, 1902 Mail Service Center, Raleigh, NC 27699-1902 shall provide, free of charge, guidelines for conducting verification and Form DHHS 3405 (Record of Tuberculosis Screening). Employees identified by agency risk assessment, to be at risk for exposure shall be subsequently tested at intervals prescribed by OSHA standards.
(c) The agency shall not hire any individual either directly or by contract who has a substantiated finding on the North Carolina Health Care Personnel Registry in accordance with G.S. 131E-256(a)(1).
(d) Written policies shall be established and implemented which include personnel record content, orientation and in-service education. Records on the subject of in-service education and attendance shall be maintained by the agency and retained as set out in Paragraph (f) of this Rule.
(e) Job descriptions for every position shall be established in writing which include qualifications and specific responsibilities. Individuals shall be assigned only to duties for which they are trained and competent to perform and when applicable for which they are licensed.
(f) Personnel records shall be established and maintained for each home care employee. When requested, the records shall be available on the agency premises for inspection by the Department. These records shall be maintained for at least one year after termination from agency employment. The records shall include the following:

(1) an application or resume which lists education, training and previous employment that can be verified, including job title;
(2) a job description with record of acknowledgment by the employee;
(3) reference checks or verification of previous employment;
(4) records of tuberculosis screening for employees for whom the test is necessary as described in Paragraph (a) of this Rule;
(5) documentation of Hepatitis B immunization or declination for hands-on care employees in accordance with the agency's exposure control plan;
(6) airborne and bloodborne pathogen training for hands on care employees, including annual updates, in compliance with 29 CFR 1910 and in accordance with the agency's exposure control plan;
(7) performance evaluations according to agency policy and at least annually. These evaluations may be confidential pursuant to Rule .0905 of this Subchapter;
(8) verification of employees' credentials as applicable; and
(9) records of the verification of competencies by agency supervisory personnel of all skills required of home care services personnel to carry out client care tasks to which the employee is assigned. The method of verification shall be defined in agency policy.

(g) For in-home aides not listed on the nurse aide registry, personnel records shall include verification of core competencies by a registered nurse that includes the following core personal care skills for in-home aides hired after April 1, 2009:

(1) Assisting with Mobility including ambulation, transfers and bed mobility;
(2) Assisting with Bath/Shower;
(3) Assisting with Toileting;
(4) Assisting with Dressing;
(5) Assisting with Eating; and
(6) Assisting with continence needs.

History Note: Authority G.S. 131E-140;
Eff. July 1, 1992;
Amended Eff. February 1, 1996; June 1, 1994;
Temporary Amendment Eff. April 1, 2006;
Amended Eff. January 1, 2010; October 1, 2006;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .1004 EVALUATION

(a) The agency's governing body or its designee shall annually conduct a comprehensive evaluation of the agency's total operation.
(b) The evaluation shall review the quality of the agency's services with findings used to verify policy implementation, to identify problems, and to establish problem resolution and policy revision as necessary.
(c) The evaluation shall consist of a policy and administration review, including the scope of services offered, arrangements for services with other agencies or individuals, admission and discharge policies, supervision and plan of care, emergency care, service records, personnel qualifications, and program evaluation. Data to be assessed shall include the following:

(1) number of clients receiving each service;
(2) number of visits or hours for each service;
(3) client outcomes;
(4) adequacy of staff to meet client needs;
(5) numbers and reasons for nonacceptance of clients; and
(6) reasons for discharge.

(d) The agency's governing body or its designee shall evaluate the agency's client records every 90 days. The evaluation shall include a review of sample active and closed client records to ensure that agency policies are followed in providing services, both direct and under contract, and to assure the quality of service meets the client's needs. The review shall consist of a representative sample of all home care services provided by the agency.
(e) Documentation of the evaluation shall include the names and qualifications of the persons carrying out the evaluation, the criteria and methods used to accomplish it, and any action taken by the agency as a result of its findings.

History Note: *Authority G.S. 131E-140;*
Eff. July 1, 1992;
RRC Objection due to lack of statutory authority Eff. November 16, 1995;
Amended Eff. February 1, 1996;
Readopted Eff. June 1, 2018.

10A NCAC 13J .1005 HOSPICE CARE

(a) If an agency offers or provides a hospice program of care, such services shall be in compliance with all provisions of 10A NCAC 13K (Hospice Licensing Rules), with the exception of rules requiring a separate hospice license.
(b) A hospice shall be eligible for a home care license if it meets the requirements of 10A NCAC 13J and meets the standards for the specific home care services offered. The extent of the licensure review shall be at the discretion of the Department.
(c) If an agency that operates a hospice, a hospice inpatient facility, or a hospice residential care facility, under its home care license, substantially fails to comply with the provisions of Article 10 of G.S. 131E or of 10A NCAC 13J, the Department may amend the agency's home care license by revoking the agency's right to operate a hospice, a hospice inpatient facility, or a hospice residential care facility, or offer hospice services under its home care license.

History Note: *Authority G.S. 131E-140;*
Eff. July 1, 1992;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .1006 NURSING POOL

(a) If an agency offers or provides a nursing pool, and does not wish to obtain a separate license for its nursing pool, such services shall be in compliance with all provisions of 10A NCAC 13L (Nursing Pool Licensing Rules).
(b) If an agency that operates a nursing pool under its home care license substantially fails to comply with the provisions of Part E of Article 6 of G.S. 131E or of 10A NCAC 13L, the Department may amend the agency's home care license by revoking the agency's right to operate a nursing pool under its home care license.

History Note: *Authority G.S. 131E-140;*
Eff. July 1, 1992;
Amended Eff. February 1, 1996;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .1007 CLIENT RIGHTS AND RESPONSIBILITIES

(a) An agency shall provide each client with a written notice of the client's rights and responsibilities in advance of furnishing care to the client or during the initial evaluation visit before the initiation of services. The agency shall maintain documentation showing that all clients have been informed of their rights and responsibilities as set forth in G.S. 131E-144.3.

(b) An agency shall provide notice to clients as set forth in G.S. 131E-144.4. The Division of Health Service Regulation shall investigate all allegations of non-compliance with rules of this Subchapter.

(c) An agency shall comply with G.S. 131E-144.6(b).

History Note: *Authority G.S. 131E-140; 131E-144.3;*
Eff. July 1, 1992;
Amended Eff. February 1, 1996;
Readopted Eff. June 1, 2018.

SECTION .1100 - SCOPE OF SERVICES

10A NCAC 13J .1101 ACCEPTANCE OF CLIENTS FOR SERVICE PROVISION

Within the scope of services provided, the agency shall develop and implement written policies governing the acceptance of clients and client services. These policies and procedures shall include the following:

(1) adequacy and suitability of agency personnel and resources to provide the services required by the client and information on resources available to cover staff absence;
(2) reasonable expectation that the client's need for requested services can be met adequately at home by the agency;
(3) adequate physical facilities in the client's home for their plan of care;
(4) availability or absence of family or substitute family member able and willing to participate in the client's care when necessary to ensure the safety of the client;
(5) information on the scope of services provided and the geographic area served with each service;
(6) notification to the referral source when one or more needed and requested services (including assessment) cannot be provided to a specific client within a time frame requested by the referral source and established by agency policy;
(7) advance notification of at least 48 hours to the client or responsible party when service provision is to be reduced or terminated, except in cases where the client is in agreement with changes, there is a danger to a client or staff member, or the physician terminates services; and
(8) referral to and coordination with other appropriate agencies when the agency is unable to respond to a request for service promptly, or to continue to provide service.

History Note: *Authority G.S. 131E-140;*
Eff. July 1, 1992;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .1102 NURSING SERVICES AND DUTIES

(a) If an agency provides nursing services, those services shall be provided by or under the supervision of a registered nurse and in accordance with the North Carolina Nursing Practice Act, G.S. Chapter 90, Article 9A, and the client's plan of care shall include the following as a minimum:

(1) regularly assess the nursing needs of the client;
(2) develop and implement the client's nursing plan of care;
(3) provide nursing services, treatment, and diagnostic and preventive procedures;
(4) initiate preventive and rehabilitative nursing procedures appropriate for the client's care and safety;
(5) observe signs and symptoms and report to the physician any reaction to treatment, drugs, or changes in the client's physical or emotional condition;

(6) teach, supervise, and counsel the client and family members about providing care for the client at home; and
(7) supervise and train other nursing service personnel.

(b) Licensed practical nurse duties are delegated by and performed under the supervision of a registered nurse. Consistent with the client's plan of care, duties may include:
(1) participating in assessment of the client's health status;
(2) implementing nursing activities, including the administration of prescribed medical treatments and medications;
(3) assisting in teaching the client and family members about providing care to the client at home; and
(4) delegating tasks to in-home aides and supervising their performance of tasks within the limitations established in 21 NCAC 36 .0225(d)(3) adopted by reference.

(c) If an agency provides nursing services, the agency shall provide on-call nursing services on a 24 hour basis, seven days a week. The agency shall retain current on-call schedules and previous schedules for one year and make them available, on request, to the Department.

History Note: *Authority G.S. 131E-140;*
Eff. July 1, 1992;
RRC Objection due to lack of statutory authority Eff. November 16, 1995;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .1103 PHYSICAL THERAPY SERVICES

(a) If an agency provides physical therapy services, such services shall be provided by or under the supervision of a licensed physical therapist and in accordance with G.S. Chapter 90, Article 18B, Physical Therapy, and the plan of care and shall include:
(1) assessment of the client to determine level of physical function;
(2) establishment and implementation of the physical therapy treatment plan;
(3) observation, recording, and reporting to the physician any reaction to treatment or changes in the client's condition;
(4) instruction of the family in the client's total physical therapy program; and
(5) instructing of family members, in-home aides and other health team personnel in performing appropriate therapy treatment.

(b) When a licensed physical therapist assistant is providing services in the home, the licensed physical therapist shall be accessible at all times clients are receiving services, and meet the supervisory requirements specified in Rule .1110 of this Section.

(c) The licensed physical therapist shall visit the client to perform all initial assessments, establish the plan of care, and perform all discharge assessments. The physical therapist shall visit to perform plan of care updates and assess the client's functional status, as prescribed in Rule .1202 of this Subchapter.

History Note: *Authority G.S. 131E-140;*
Eff. July 1, 1992;
RRC Objection due to lack of statutory authority Eff. November 16, 1995;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .1104 SPEECH THERAPY/PATHOLOGY SERVICES

If an agency provides speech therapy, or services in speech and language pathology or audiology such services shall be provided in accordance with G.S. 90, Article 22, North Carolina Licensure Act for Speech and Language Pathologists and Audiologists and the client's plan of care and shall include the following at a minimum:
(1) assessment of clients with speech, language, voice, dysphagia, and/or hearing disorders;
(2) establishment and implementation of the speech therapy treatment plan;
(3) recording and reporting to the physician any reaction to treatment or changes in the client's condition;

(4) teaching other health team personnel and family members techniques to help improve and correct the client's speech, language, voice, dysphagia, or hearing potential; and
(5) counseling the client and family about the client's speech, language, voice, dysphagia, and/or hearing disabilities.

History Note: Authority G.S. 131E-140;
Eff. July 1, 1992;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .1105 OCCUPATIONAL THERAPY SERVICES

(a) If an agency provides occupational therapy, such services shall be provided by or under the supervision of a licensed occupational therapist in accordance with G.S. Chapter 90, Article 18D, Occupational Therapy and the client's plan of care and shall include:
(1) assessment of the client's functional ability to perform activities of daily living;
(2) establishment and implementation of the occupational therapy treatment plan;
(3) observation, recording, and reporting to the physician any reaction to treatment and any changes in the client's condition;
(4) instruction of family members, in-home aides and other health team personnel in appropriate therapy methods; and
(5) design, development and fitting orthotic devices and self-help devices.

(b) When a certified occupational therapist assistant is providing services in the home, the licensed occupational therapist shall be accessible at all times clients are receiving services, and meet the supervisory requirements specified in Rule .1110 of this Section.

(c) The licensed occupational therapist shall visit the client to perform all initial assessments, establish the plan of care, and perform all discharge assessments. The occupational therapist shall visit to perform plan of care updates as described in Rule .1202 of this Subchapter.

History Note: Authority G.S. 131E-140;
Eff. July 1, 1992;
RRC Objection due to lack of statutory authority Eff. November 16, 1995;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .1106 MEDICAL SOCIAL WORK SERVICES

If an agency provides medical social work services, such services shall be provided by or under the supervision of a medical social worker and in accordance with the client's plan of care and shall include the following:
(1) assisting the physician and other members of the health team in understanding the significant social and emotional factors related to the client's health problems;
(2) assessing social and emotional factors in order to estimate the client's capacity and potential to cope with problems of daily living;
(3) helping the client and family to understand, accept, and follow medical recommendations and provision of services planned to restore the client to optimum social and health adjustment within their capacity;
(4) assisting the client and family with personal and environmental difficulties which predispose toward illness or interfere with the client obtaining maximum benefits from medical care; and
(5) assisting the client and family in the utilization of appropriate community resources.

History Note: Authority G.S. 131E-140;
Eff. July 1, 1992;
RRC Objection due to lack of statutory authority Eff. November 16, 1995;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .1107 IN-HOME AIDE SERVICES

(a) If an agency provides in-home aide services, the services shall be provided in accordance with the client's plan of care. The plan of care shall be signed and dated by the health care practitioner and the client or the client's responsible party. The client shall have access to a copy of the in-home aide plan of care in the home.

(b) The plan of care shall contain the level of assistance required by the client for each ADL. If the client's plan of care requires the in-home aide to provide extensive assistance, the in-home aide shall be listed on the Nurse Aide Registry pursuant to G.S. 131E-255. However, if the client's plan of care requires the in-home aide to provide only limited assistance, the in-home aide is not required to be listed on the Nurse Aide Registry.

(c) In-home aides shall follow instructions for client care written by the health care practitioner. In-home aide duties may include the following:

(1) help with prescribed exercises that the client and in-home aides have been taught by a health care practitioner;
(2) provide or assist with ADLs;
(3) assist client with self-administration of medications that are ordered by a health care practitioner or other person authorized by state law to prescribe;
(4) perform IADLs that are essential to the client's care at home; and
(5) record and report changes in the client's condition, family situation, or needs to the health care practitioner.

(d) For agencies providing in-home aide services, the initial assessment shall be conducted in the client's home by the health care practitioner. The initial assessment shall include the client's functional status in the areas of social, mental, physical health, environmental, economic, ADLs, and IADLs.

(e) The initial assessment shall be conducted prior to the development of the plan of care and signed and dated by the health care practitioner.

(f) Agencies providing in-home aide services shall provide availability of the health care practitioner for supervision and consultation.

(g) Agencies participating in the Home and Community Care Block Grant or Social Services Block Grant through the Division of Aging and Adult Services shall comply with the in-home aide service level rules contained in 10A NCAC 06A and 10A NCAC 06X, which are hereby incorporated by reference with all subsequent amendments and editions. Copies of these rules may be accessed at no cost at http://reports.oah.state.nc.us/ncac.asp?folderName=\Title 10A - Health and Human Services\Chapter 06 - AGING - PROGRAMS OPERATIONS.

(h) In order to assure supervision of services provided by in-home caregivers, geographic service areas for these services shall be limited to the area that includes the county where the agency is located, counties that are contiguous with the county where the agency is located, or within 90 minutes driving time from the site where the agency is located, whichever is greater. Agencies providing services to any client prior to January 1, 2006 who resides in a geographic service area that prior to January 1, 2006 is beyond the counties that are contiguous with the county where the agency is located or greater than 90 minutes driving time from the site where the agency is located, may continue to provide services to the client in these areas until the client is discharged from the agency.

History Note: *Authority G.S. 131E-140;*
Eff. July 1, 1992;
Amended Eff. January 1, 2010; October 1, 2007; October 1, 2006; February 1, 1996;
Readopted Eff. June 1, 2018.

10A NCAC 13J .1108 INFUSION NURSING SERVICES

(a) If an agency provides infusion nursing services, the services shall be provided by or under the supervision of a registered nurse with training in infusion services or special training in the drug and nutritional therapies the agency offers, as identified in agency policies, and in accordance with the North Carolina Nursing Practice Act, G.S. Chapter 90, Article 9A, and a plan of care signed by a physician.

(b) If an agency provides or arranges for infusion services, the agency shall provide on-call infusion nursing services on a 24 hour basis, seven days a week.

(c) If the agency provides or contracts for infusion pharmacy services there shall be policies and procedures governing the scope of pharmacy services provided. Pharmacy services shall be provided in accordance with the Pharmacy Laws of North Carolina and related rules and shall be provided on a 24-hour basis, seven days a week.

History Note: Authority G.S. 131E-140;
Eff. July 1, 1992;
RRC Objection due to lack of statutory authority Eff. November 16, 1995;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .1109 CLINICAL RESPIRATORY SERVICES, INCLUDING PULMONARY, OR VENTILATION SERVICES

(a) If an agency provides clinical respiratory services or ventilation services, the services shall be provided by or under the supervision of a respiratory therapist or a registered nurse with demonstrated competency in the delivery of respiratory services under a plan of care signed by a physician. Within the agency's defined scope of service, respiratory staff, including contractors, shall maintain an active license, certification or registry and shall demonstrate proof of education and experience sufficient for the safe delivery of service.
(b) Clinical respiratory services shall include the following:
(1) assessment of the client's ongoing need for services;
(2) teach and train client or caregivers to self-administer home respiratory care procedures;
(3) collect laboratory specimens;
(4) evaluate functioning of ventilator support equipment;
(5) evaluate functioning of infant monitors; and
(6) when ordered by a physician, administration of aerosolized medication.
(c) If an agency provides these services, the agency shall provide on-call respiratory services emergency response on a 24 hour basis, seven days a week.

History Note: Authority G.S. 131E-140;
Eff. July 1, 1992;
RRC Objection due to lack of statutory authority and ambiguity Eff. November 16, 1995;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .1110 SUPERVISION AND COMPETENCY OF IN-HOME CAREGIVERS

(a) In-home caregivers subject to occupational licensing laws shall meet requirements consistent with the rules established by the occupational licensing board that they are subject. Each agency shall document that its in-home caregivers are competent to perform client care tasks or activities that they are assigned. Meeting competency includes a demonstration of tasks to the health care practitioner. In-home caregivers shall perform delegated activities under the supervision of persons authorized by state law to provide such supervision.
(b) Those in-home caregivers who are not subject to occupational licensing laws shall only be assigned client care activities that they have demonstrated competency, and the documentation of competency is maintained by the agency. Meeting competency includes a demonstration of tasks to the health care practitioner. Each agency shall document that its in-home caregivers demonstrate competence for all assigned client care tasks or activities. In-home caregivers shall be supervised by the health care practitioner who may further delegate specific supervisory activities to in-home caregivers as designated by agency policy, provided that the following criteria are met:
(1) there is availability of the health care practitioner for supervision and consultation; and
(2) accountability for supervisory activities delegated is maintained by the health care practitioner.
(c) In-home caregivers subject to Paragraph (a) of this Rule shall be subject to the method and frequency of supervision defined in the agency's policy. The health care practitioner shall supervise an in-home caregiver subject to Paragraph (b) of this Rule by making a supervisory visit to each client's place of residence every 90 days with or without the in-home caregiver's presence, and annually, while the in-home caregiver is providing care to each client. The supervisory visit shall include review of the client's general condition, progress, and response to the services provided by the in-home caregiver.
(d) Documentation of supervisory visits shall be maintained in the agency's records and shall contain date of visit, findings of visit, and signature of person performing the visit.
(e) When follow-up corrective action is needed for any type of in-home caregiver based on findings of the supervisory visit, documentation of such corrective action by the health care practitioner shall be maintained in the employee(s) record.

(f) A health care practitioner conducting a supervisory visit for any in-home caregiver may simultaneously conduct the case review every 90 days as required in Rule .1202 of this Subchapter.
(g) The health care practitioner shall be available for supervision during the hours that in-home care services are provided.

History Note: Authority G.S. 131E-140;
Eff. July 1, 1992;
Amended Eff. July 1, 1993;
RRC Objection due to lack of statutory authority and ambiguity Eff. November 16, 1995;
Amended Eff. February 1, 1996;
Temporary Amendment Eff. April 1, 2006;
Amended Eff. November 1, 2006;
Readopted Eff. June 1, 2018.

10A NCAC 13J .1111 ARRANGEMENTS FOR SERVICES WITH OTHER AGENCIES OR INDIVIDUALS

(a) When an agency makes arrangements for providing services through other agencies or individuals, or where the agency contracts with a state or county agency to provide licensed home care services, there shall be a written agreement, signed by both parties, which includes the following:

(1) specific service to be provided;
(2) period of time the contract is to be in effect;
(3) availability of services;
(4) financial arrangements;
(5) verification that any individual providing service is appropriately licensed or registered as required by statute;
(6) provision for supervision of contract personnel where applicable;
(7) assurance that individuals providing services under contractual arrangements meet the same requirements as those specified for home care agency personnel;
(8) provision for the documentation of services rendered in the client's service record;
(9) provision for the sharing of assessment and plan of care data; and
(10) the geographic service area the contractor agrees to serve.

(b) All contract services shall be provided in accordance with the client's plan of care.
(c) The agency shall assure that all contract services are provided in accordance with the agreement. Agreements are to be reviewed and updated, if necessary, on an annual basis.
(d) The agency who is subcontracting its work must maintain or produce a complete home care record for the client.

History Note: Authority G.S. 131E-140;
Eff. July 1, 1992;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .1112 HOME MEDICAL EQUIPMENT AND SUPPLIES

If an agency provides medical supplies and equipment in conjunction with home care services as defined in G.S. 131E-136(3), the agency shall have policies and procedures governing their management. These policies shall address the following:

(1) set-up, delivery, electrical safety, and environmental requirements for equipment.
(2) proper cleaning and storage, preventive maintenance, and repair according to manufacturer's guidelines.
(3) transportation, tracking, and recall of equipment to meet all applicable regulatory requirements.
(4) emergency preparedness and backup of systems for equipment or power failure.
(5) client instruction materials for each item of home medical equipment or supplies provided.

History Note: Authority G.S. 131E-140;
Eff. February 1, 1996;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

SECTION .1200 - CASE REVIEW AND PLAN OF CARE

10A NCAC 13J .1201 POLICIES

An agency shall develop and implement written policies and procedures to assure that services and items to be provided are specified under a plan of care.

History Note: *Authority G.S. 131E-140;*
Eff. July 1, 1992;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .1202 CASE REVIEW AND PLAN OF CARE

(a) The plan of care shall be established in collaboration with the client and incorporated in the service record. The plan of care shall be reviewed every 90 days by the health care practitioner and revised as needed based on the client's needs. If the client record is purged, the original and updated authorization or orders for care shall be maintained in the client's record. All records shall be available to Department staff for review if requested. If physician orders are needed for the services, the health care practitioner shall notify the physician of any changes in the client's condition that indicates the need for altering the plan of care or for terminating services. Based upon the findings of the client assessment, the plan of care shall include the following:

(1) type of service(s) and care to be delivered;
(2) frequency and duration of service;
(3) activity restrictions;
(4) safety measures; and
(5) service objectives and goals.

(b) Where applicable, the plan of care shall include:

(1) equipment required;
(2) functional limitations;
(3) rehabilitation potential;
(4) diet and nutritional needs;
(5) medications and treatments;
(6) specific therapies;
(7) pertinent diagnoses; and
(8) prognosis.

(c) If the health care practitioner is assigned responsibility for two or more of the following, these functions may be conducted during the same home visit:

(1) assessment of client's condition, progress, and response every 90 days;
(2) provision of regularly scheduled professional services; or
(3) supervision of in-home caregiver.

History Note: *Authority G.S. 131E-140;*
Eff. July 1, 1992;
Amended Eff. May 1, 1993;
RRC Objection due to lack of statutory authority Eff. November 16, 1995;
Amended Eff. February 1, 1996;
Readopted Eff. June 1, 2018.

SECTION .1300 - PHARMACEUTICALS AND MEDICAL TREATMENT ORDERS

10A NCAC 13J .1301 POLICIES, PROCEDURES, AND STAFF RESPONSIBILITY

If the agency administers any pharmaceuticals or medical treatments, it shall develop and implement policies and procedures relative to the administration of pharmaceuticals and treatments. The policies shall specify staff accountability for:

(1) recognizing side effects;
(2) recognizing toxic effects;
(3) recognizing allergic reactions;
(4) recognizing immediate desired effects;
(5) recognizing unusual and unexpected effects;
(6) recognizing changes in the client's condition that contraindicates continued administration of the medication;
(7) anticipating those effects which may rapidly endanger a client's life or well-being; and
(8) notifying the physician of any problems.

History Note: *Authority G.S. 131E-140;*
Eff. July 1, 1992;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .1302 ORDERS

(a) Orders for pharmaceuticals and medical treatments, or orders for in-home aide services when orders for in-home aide services are required, shall be signed by the physician or other person authorized by State law to prescribe such treatments and the original incorporated in the client's service records. Care may commence in the interim with a verbal order.
(b) Verbal orders for the administration of pharmacological agents and other medical treatment interventions shall be given to a licensed nurse, or other person authorized by state law to receive such orders. The order once recorded shall include the date and signature of the person receiving the order, shall be recorded in the client record, and shall be countersigned by the physician or other person authorized by State law to prescribe.
(c) Verbal orders for allied health services personnel, other than nursing or other than in-home aide services, shall be given to either a licensed nurse or the appropriate health professional. The order once recorded shall include the date and signature of the person receiving the order, shall be recorded in the client record and shall be countersigned by the physician or other person authorized by State law to prescribe.
(d) The home care agency shall develop and implement written policies and procedures for obtaining countersignatures on verbal orders within 60 days of the date of the verbal order.

History Note: *Authority G.S. 131E-140;*
Eff. July 1, 1992;
Amended Eff. February 1, 2004; February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .1303 RESERVED FOR FUTURE CODIFICATION

SECTION .1400 - SERVICE RECORDS

10A NCAC 13J .1401 REQUIREMENT

(a) The agency shall develop and implement written policies governing content and handling of client records.
(b) The agency shall maintain a client record for each client. Each page of the client record shall have the client's name. All entries in the record shall reflect the actual date of entry. When agency staff make additional, late, or out of sequence entries into the client record, the documentation shall include the following applicable notations: addendum, late entry, or entry out of sequence, and the date of the entry. A system for maintaining originals and copies shall be described in the agency policies and procedures.
(c) The agency shall assure that originals of client records are kept confidential and secure on the licensed premises unless in accordance with Rule .0905 of this Subchapter, or subpoenaed by a court of legal jurisdiction, or to conduct an evaluation as required in Rule .1004 of this Subchapter.
(d) If a record is removed to conduct an evaluation, the record shall be returned to the agency premises within five working days. The agency shall maintain a sign out log that includes to whom the record was released, client's name and date removed. Only authorized staff or other persons authorized by law may remove the record for these purposes.

(e) A copy of the client record for each client must be readily available to the appropriate health professional(s) providing services or managing the delivery of such services.
(f) Client records shall be retained for a period of not less than five years from the date of the most recent discharge of the client, unless the client is a minor in which case the record must be retained until three years after the client's 18th birthday. When an agency ceases operation, the Department shall be notified in writing where the records will be stored for the required retention period.

History Note: *Authority G.S. 131E-140;*
Eff. July 1, 1992;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .1402 CONTENT OF RECORD

(a) If the agency is providing services to a client, the service record shall contain the following information:

(1) Admission data:
(A) identification data such as name, address, telephone number, date of birth, sex, and marital status;
(B) a copy of the signed client's rights form or documentation of its delivery;
(C) names of next of kin, legal guardian, or other family members;
(D) source of referral; and
(E) assessment of home environment.

(2) Service data:
(A) initial assessments by the health care practitioner of the client's functional status in the areas of social, mental, physical health, environmental, economic, ADLs, and IADLs;
(B) identification of problems, the establishment of goals and proposed intervention, and indication of the client's understanding of and approval for services to be provided. If the client is diagnosed as not competent, the approval of the client's responsible party shall be recorded;
(C) a record of all services provided with entries with date and time of service, and signed by the individual providing the service;
(D) discharge summary that includes an overall summary of services provided by the agency and the date and reason for discharge. When a specific service to a client is terminated and other services continue, there shall be documentation of the date and reason for terminating the specific service; and
(E) evidence of coordination of services when the client is receiving more than one in-home care service.

(b) If the agency is providing services to a client that require a physician's order, the service record shall include all of the items described in Paragraph (a) of this Rule and the following items:

(1) Admission data:
(A) admission and discharge dates from hospital or other institution when applicable; and
(B) names of physician(s) responsible for the client's care.

(2) Service data:
(A) client's diagnoses;
(B) physician's orders for pharmaceuticals and medical treatments; and
(C) if the agency is providing services to a hospital or nursing facility patient, the agency's record shall include referral information, dates and times of services, and documentation of services provided.

History Note: *Authority G.S. 131E-140;*
Eff. July 1, 1992;
Amended Eff. February 1, 1996;
Readopted Eff. June 1, 2018.

SECTION .1500 – COMPANION, SITTER, AND RESPITE SERVICES

10A NCAC 13J .1501 DEFINITIONS

The following definitions shall apply throughout this Section:

(1) "Companion, sitter, or respite services personnel" means an individual as used in G.S. 131E-136, who spends time with or provides non-hands-on care services for clients.

(2) "Non-Hands-on Care Services" means basic home management tasks, shopping, meal preparation, transportation, companion services, socialization, medication reminders, and other services that do not require the service provider to use "hands-on care" as defined in Rule .0901 of this Subchapter and which do not require training or verification of skills by a Registered Nurse.

(3) "Respite Care" means planned or emergency care provided to an individual in order to provide temporary relief to the family caregiver.

History Note: Authority G.S. 131E-140;
Eff. January 1, 2010;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .1502 SCOPE OF SERVICES

(a) If an agency provides In-home companion, sitter, or respite services, the services shall be provided in accordance with the client's plan of care. Agencies participating in the Home and Community Care Block Grant or Social Services Block Grant through the Division of Aging and Adult Services shall comply with the service level rules contained in 10A NCAC 06A and 10A NCAC 06X. All other agencies providing in-home companion, sitter, or respite services shall comply with the provisions of the rules in this Section.

(b) In-home companion, sitter, or respite services personnel shall follow the plan of care written by the in-home companion, sitter, or respite services supervisor.

History Note: Authority G.S. 131E-140;
Eff. January 1, 2010;
Readopted Eff. June 1, 2018.

10A NCAC 13J .1503 AGENCY MANAGEMENT AND SUPERVISION

Notwithstanding the requirements in Rule .1001 of this Subchapter, the agency shall meet the following requirements:

(1) The agency shall designate an individual to serve as agency director. The agency director shall have the authority and responsibility for administrative direction of the agency. The agency director shall be a high school graduate, or be certified under the G.E.D. Program, and shall meet one or more of the following qualifications:
  (a) shall be a health care practitioner as defined in G.S. 90-640(a); or
  (b) shall have one year experience in home care, companion, sitter, or respite services, or any other provider licensed pursuant to G.S. 131E or G.S. 122C.

(2) The agency shall designate a person responsible for supervising non-hands-on care services that is provided by the agency either directly or by contract. This individual may be the supervisor for the companion, sitter, or respite services and may also serve as the agency director.

History Note: Authority G.S. 131E-140;
Eff. January 1, 2010;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

10A NCAC 13J .1504 SUPERVISION AND COMPETENCY OF COMPANION, SITTER, AND RESPITE SERVICES

In addition to the requirements in Rule .1110 of this Subchapter, an agency providing In-home companion, sitter, or respite care services shall meet the following requirements:

(1) Each agency shall have documentation that its companion and sitters are competent to perform client care tasks or activities to which they are assigned. Such individuals shall perform delegated activities under the supervision of a supervisor designated by agency policy for the services assigned.

(2) The agency designated supervisor shall supervise the companion and sitter staff by contacting the client receiving care every three months and by making a supervisory visit to each client's place of residence at least every six months, with or without the companion and sitter's presence, and at least annually, while the companion or sitter is in the home providing services to the client.

(3) The supervisory visit shall include a review of the client's general condition, monitoring progress and response to the services provided by the companion or sitter, and updates to the plan of care as needed.

(4) Documentation of supervisory visits shall be maintained in the agency's records and shall contain the following:
   - (a) date of visit;
   - (b) findings of visit; and
   - (c) signature of person performing the visit.

(5) The agency designated supervisor conducting a supervisory contact for a companion, sitter, or respite provider may simultaneously conduct the quarterly case review as required in Rule .1202 of this Subchapter.

(6) The agency directed supervisor shall be available for supervision, on-site where services are provided when necessary, during the hours that companion, sitter, or respite services are provided.

History Note: *Authority G.S. 131E-140;*
Eff. January 1, 2010;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 25, 2016.

SUBCHAPTER 13K – HOSPICE LICENSING RULES

SECTION .0100 – GENERAL INFORMATION

10A NCAC 13K .0101 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13K .0102 DEFINITIONS

In addition to the definitions set forth in G.S. 131E-201, the following definitions shall apply throughout this Subchapter:

(1) "Agency" means a licensed hospice as defined in G.S. 131E-201(3).

(2) "Care Plan" means the proposed method developed in writing by the interdisciplinary care team through which the hospice seeks to provide services that meet the patient's and family's medical, psychosocial, and spiritual needs.

(3) "Clergy Member" means an individual who has received a degree from a theological school and has fulfilled denominational seminary requirements; or an individual who, by ordination or authorization from the individual's denomination, has been approved to function in a pastoral capacity. Each hospice shall designate a clergy member responsible for coordinating spiritual care to hospice patients and families.

(4) "Coordinator of Patient Family Volunteers" means an individual on the hospice team who coordinates and supervises the activities of all patient family volunteers.

(5) "Dietary Counseling" means counseling given by a licensed dietitian/nutritionist or licensed nutritionist as defined in G.S. 90-352.

(6) "Director" means the person having administrative responsibility for the operation of the hospice.

(7) "Division" means the Division of Health Service Regulation of the North Carolina Department of Health and Human Services.

(8) "Governing Body" means the group of persons responsible for overseeing operations of the hospice, including the development and monitoring of policies and procedures related to all aspects of the operations of the hospice program. The governing body ensures that all services provided are consistent with accepted standards of hospice practice.

(9) "Hospice" means a coordinated program of services as defined in G.S. 131E-201.

(10) "Hospice Caregiver" means an individual on the hospice team who has completed hospice caregiver training as defined in Rule .0402 of this Subchapter and is assigned to a hospice residential facility or hospice inpatient unit.
(11) "Hospice Inpatient Facility or Hospice Inpatient Unit" means as defined in G.S. 131E-201(3a).
(12) "Hospice Residential Facility" means as defined in G.S. 131E-201(5a).
(13) "Hospice Team" means as defined in G.S. 131E-201(6).
(14) "Informed Consent" means the agreement to receive hospice care made by the patient and family that specifies in writing the type of care and services to be provided. The informed consent form shall be signed by the patient prior to service. If the patient's medical condition is such that a signature cannot be obtained, a signature shall be obtained from the individual having legal guardianship, applicable durable or health care power of attorney, or the family member or individual assuming the responsibility of primary caregiver.
(15) "Interdisciplinary Team" means as defined in G.S. 131E-201(6).
(16) "Licensed Practical Nurse" means as defined in G.S. 90-171.30 or G.S. 171.32.
(17) "Medical Director" means a physician licensed to practice medicine in North Carolina who directs the medical aspects of the hospice's patient care program.
(18) "Nurse Practitioner" means as defined in G.S. 90-18.2(a).
(19) "Nurse Aide" means an individual who is authorized to provide nursing care under the supervision of a licensed nurse, has completed a training and competency evaluation program or competency evaluation program and is listed on the Nurse Aide Registry, at the Division of Health Service Regulation. If the nurse aide performs Nurse Aide II tasks, the nurse aide shall also meet the requirements established by the N.C. Board of Nursing as defined in 21 NCAC 36 .0405, incorporated by reference including subsequent amendments.
(20) "Patient and Family Care Coordinator" means a registered nurse designated by the hospice to coordinate the provision of hospice services for each patient and family.
(21) "Patient Family Volunteer" means an individual who has received orientation and training as defined in Rule .0402 of this Subchapter, and provides volunteer services to a patient and the patient's family in the patient's home or in a hospice inpatient facility or hospice inpatient unit, or a hospice residential facility.
(22) "Pharmacist" means as defined in G.S. 90-85.3.
(23) "Physician" means as defined in G.S. 90-9.1 or G.S. 90-9.2.
(24) "Premises" means the location or licensed site where the agency provides hospice services or maintains patient service records or advertises itself as a hospice agency.
(25) "Primary Caregiver" means the family member or other person who assumes the overall responsibility for the care of the patient in the patient's home.
(26) "Registered Nurse" means as defined in G.S. 90-171.30 or G.S. 90-171.32.
(27) "Respite Care" means care provided to a patient for temporary relief to family members or others caring for the patient at home.
(28) "Spiritual Caregiver" means an individual authorized by the patient and family to provide for their spiritual needs.

History Note: *Authority G.S. 131E-202;*
Eff. November 1, 1984;
Amended Eff. February 1, 1996; February 1, 1995; June 1, 1991; November 1, 1989;
Readopted Eff. January 1, 2021.

SECTION .0200 - LICENSE

10A NCAC 13K .0201 LICENSE REQUIRED

Each hospice agency premises shall obtain a license unless exempted by G.S. 131E-203.

History Note: *Authority G.S. 131E-202;*
Eff. November 1, 1984;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .0202 APPLICATION FOR AND ISSUANCE OF A LICENSE

(a) An application for a license to operate a hospice agency or facility shall be submitted to the Department prior to the scheduling of an initial licensure survey. The hospice agency shall establish, maintain and make available for inspection such documents, records and policies as required in this Section and statistical data sufficient to complete the licensure application and upon request of the Department, to submit an annual data report, including all information required by the Department as noted in Rule .0303 of this Subchapter.

(b) The Department shall issue a license to each hospice agency premises when determined to be in compliance with licensure rules. Initial licensure inspections shall be conducted at the Department offices. On-site inspections shall include one or all sites as described in Rule .0209 of this Subchapter. Initial licensure shall be for a period of not more than one year. Subsequent licensure shall extend for a minimum of one year and a maximum of three years, at the discretion of the Department. Each license shall expire at midnight on the expiration date on the license and is renewable upon application.

(c) The license shall be posted in a prominent location accessible to public view within the premises. The agency shall also post a sign at the public access door with the hospice agency name.

(d) The license shall be issued for the premise and persons named in the application and shall not be transferable. The name and street address under which the agency operates shall appear on the license. If the agency operates an inpatient facility or unit, or a residential facility to provide inpatient or residential hospice care, the number of beds for each shall be reflected on the license.

(e) Prior to change of ownership or the establishment of a new hospice agency, the agency shall be in compliance with all the applicable statutes and rules established under Article 10 of G.S. 131E.

(f) The licensee shall notify the Department in writing of any proposed change in ownership or name at least 30 days prior to the effective date of the change.

History Note: *Authority G.S. 131E-202;*
Eff. November 1, 1984;
Amended Eff. April 1, 1996; June 1, 1991; November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .0203 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13K .0204 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13K .0205 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13K .0206 ADVERSE ACTION

A hospice may appeal any adverse decision made by the Department concerning its license by making such appeal in accordance with the Administrative Procedure Act, G.S. 150B and Departmental Rules 10ANCAC 01 et seq. As provided for in G.S. 131E-206, the Department shall seek injunctive relief to prevent an entity from establishing or operating a hospice agency without a license.

(1) The Department may amend a license by reducing it from a full license to a provisional license whenever the Department finds that:
  (a) the licensee has substantially failed to comply with the provisions of Article 10 of G.S. 131E and the rules promulgated under that Part; and
  (b) there is a reasonable probability that the licensee can remedy the licensure deficiencies within a reasonable length of time; and
  (c) there is a reasonable probability that the licensee will be able thereafter to remain in compliance with the hospice licensure rules for the foreseeable future.

The Department shall give the licensee written notice of the amendment of its license. This notice shall be given by registered or certified mail or by personal service and shall set forth the reasons for the action.

(2) The provisional license shall be effective immediately upon its receipt by the licensee and must be posted in a prominent location, accessible to public view, within the licensed premises in lieu of the full license. The provisional license shall remain in effect until:
  (a) the Department restores the licensee to full licensure status; or
  (b) the Department revokes the licensee's license; or

(c) the end of the licensee's licensure year.

If a licensee has a provisional license at the time that the licensee submits a renewal application, the license, if renewed, shall also be provisional license unless the Department determines that the licensee can be returned to full license status. A decision to issue a provisional license shall be stayed during the pendency of an administrative appeal and the licensee may continue to display its full license during the appeal.

(3) The Department may revoke a license whenever:
 (a) The Department finds that:
  (i) the licensee has substantially failed to comply with the provisions of Article 10 of G.S. 131E and the rules promulgated under those parts; and
  (ii) it is not reasonably probable that the licensee can remedy the licensure deficiencies within a reasonable length of time; or
 (b) The Department finds that:
  (i) the licensee has substantially failed to comply with the provisions of Article 10 of G.S. 131E; and
  (ii) although the licensee may be able to remedy the deficiencies within a reasonable time, it is not reasonably probable that the licensee will be able to remain in compliance with the hospice licensure rules for the foreseeable future; or
 (c) The Department finds that there has been any failure to comply with the provisions of Article 10 of G.S. 131E and the rules promulgated under those parts that endangers the health, safety or welfare of the patients receiving services from the agency.

The issuance of a provisional license is not a procedural prerequisite to the revocation of a license pursuant to Sub-Item (3)(a), (b) or (c) of this Rule.

History Note: Authority G.S. 131E-202;
Eff. November 1, 1984;
Amended Eff. February 1, 1996; November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .0207 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13K .0208 INSPECTIONS

(a) Any hospice agency or facility shall be subject to inspections by authorized representatives of the Department at any time as a condition of holding such license.

(b) Any person or organization subject to licensure which presents itself to the public as a hospice which does not hold a license, and is or may be in violation of Rule .0202 of this Section and G.S. 131E-203(a) shall be subject to proper inspections at any time by authorized representatives of the Department.

(c) Representatives of the Department shall make their identities known to the person in charge prior to the inspection.

(d) Licensure inspection of medical records shall be carried out in accordance with G.S. 131E-207.

(e) An inspection shall be conducted whenever the purpose of the inspection is to determine whether the agency complies with the provisions of this Subchapter or whenever there is reason to believe that some condition exists which is not in compliance with the rules in this Subchapter. The agency shall allow immediate access to its premises and the records necessary to conduct an inspection and determine compliance with the rules of this Subchapter. Failure to do so shall result in termination of the survey and may result in injunctive relief as outlined in G.S. 131E-206.

(f) An agency shall file a plan of correction for cited deficiencies within 10 working days of receipt of a report of deficiencies. The Department shall review and respond to a written plan of correction within 10 working days of receipt.

(g) Representatives of the Department may visit patients in their homes to assess the agency's compliance with the patients' plans of care and with the licensure rules. Patients shall be contacted by the hospice agency staff in the presence of the Department staff for permission to visit.

History Note: Authority G.S. 131E-202;
Eff. November 1, 1984;
Amended Eff. February 1, 1996;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .0209 MULTIPLE PREMISES

If a person operates multiple hospice agency premises:

(1) the Department may conduct inspections at any or all of the premises and may issue a license to each of the premises based upon inspection of any or all of the premises;

(2) with 72 hours advance notice, the Department may request records from any of the premises necessary to ensure compliance with the rules of this Subchapter be brought to the site being inspected, including the portions of personnel records subject to review. For agencies for whom a business or government policy precludes the disclosure of employee evaluations, a statement signed by the employee's supervisor attesting to its completion shall be accepted;

(3) the premises may share staff or administrative staff, and may centralize the maintenance of records.

History Note: *Authority G.S. 131E-202;*
Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .0210 COMPLIANCE WITH LAWS

(a) The hospice agency shall be in compliance with all applicable federal, state and local laws, rules and regulations.

(b) Staff of the hospice agency shall be currently licensed, listed or registered in accordance with applicable laws of the State of North Carolina.

History Note: *Authority G.S. 131E-202;*
Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

SECTION .0300 - ADMINISTRATION

10A NCAC 13K .0301 AGENCY MANAGEMENT AND SUPERVISION

(a) The governing body or its designee shall establish and implement at a minimum, a description of written policies governing all aspects of the hospice program. Such policies shall be available for inspection by the Department and shall include at a minimum:

(1) provision for offering of the full scope of hospice services in the agency's defined service area;
(2) admission and discharge policies;
(3) patient's rights policies, including the right to have an advance directive;
(4) personnel policies and records;
(5) orientation, patient family volunteer training, and inservice education policies;
(6) communicable disease exposure and infection control policies;
(7) care planning and updates policies;
(8) medical record content and handling of orders for drug treatment administration;
(9) annual evaluation of the agency;
(10) storage, preventive maintenance, and infection control of supplies and equipment;
(11) handling of complaints about services; and
(12) emergency preparedness and disaster planning.

(b) The governing body shall designate an individual to serve as agency director.

(c) There shall be written policies that specify the authority and responsibilities of the director. In the event this position becomes vacant, the Department shall be notified in writing within five working days of the vacancy along with the name of the replacement if available. Agency policies shall define the order of authority in the absence of the administrator.

(d) The agency shall have the ultimate responsibility for the services provided under its license; however, it may make arrangements with contractors and others to provide services in accordance with Rule .0505 of this Subchapter.
(e) A hospice agency shall have written policies which identify the specific geographic areas in which the agency provides its services.
(f) If an agency plans to permanently expand its geographic service area beyond that currently on file with the Department without opening an additional site, the Department shall be notified in writing 30 days in advance. The agency must offer its full scope of hospice services in its entire geographic service area.

History Note: Authority G.S. 131E-202;
Eff. November 1, 1984;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .0302 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13K .0303 ADMINISTRATIVE FINANCIAL AND STATISTICAL RECORDS
(a) The hospice shall establish, maintain and make available for inspection the hospice annual budget.
(b) The hospice shall record, maintain and make available to the Department statistical records as requested. Records shall include: hours worked by staff, including patient family volunteers; patient census information regarding the numbers of referrals, admissions and discharges; and patient diagnoses and service location (home or inpatient).
(c) Records shall be retained for a period of not less than five years.
(d) When a hospice agency or facility operates as a part of a health care facility licensed under Article 5 or 6 of G.S. 131E, or as part of a larger diversified agency, records of hospice activities and expenditures that are separate and identifiable shall be maintained for the hospice agency.

History Note: Authority G.S. 131E-202;
Eff. November 1, 1984;
Amended Eff. February 1, 1996; November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

SECTION .0400 - PERSONNEL

10A NCAC 13K .0401 PERSONNEL
(a) Written policies shall be established and implemented by the agency regarding infection control and exposure to communicable diseases consistent with the rules set forth in 10A NCAC 41A, which is incorporated by reference, including subsequent amendments. These policies and procedures shall include provisions for compliance with 29 CFR 1910 Occupational Safety and Health Standards, which is incorporated by reference including subsequent amendments and editions. These editions shall include 29 CFR 1910.1030 Bloodborne Pathogens. Copies of Title 29 Part 1910 can be obtained online at no charge at https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=10051&p_table=STANDARDS.
(b) Hands-on care team members shall have a baseline test for tuberculosis. Individuals who test positive shall demonstrate non-infectious status prior to assignment in a patient's home. Individuals who have previously tested positive for the tuberculosis test shall obtain a baseline and subsequent annual verification that they are free of tuberculosis symptoms. The verification shall be obtained from the local health department, a private physician, or health nurse employed by the agency. The Communicable Disease Branch of the North Carolina Department of Health and Human Services, Division of Public Health, 1905 Mail Service Center, Raleigh, NC 27699-1905 will provide free of charge guidelines for conducting and verification utilizing Form DHHS 3405 (Record of Tuberculosis Screening). Employees identified by agency risk assessment to be at risk for exposure shall be subsequently tested in accordance with Centers for Disease Control (CDC) guidelines, which is incorporated by reference with subsequent amendments and editions. A copy of the CDC guidelines can be obtained online at no charge at https://search.cdc.gov/search/?query=TB+testing+intervals&sitelimit=&utf8=%E2%9C%93&affiliate=cdc-main.

(c) Written policies shall be established and implemented by the agency that include personnel record content, orientation, patient family volunteer training, and in-service education. Records on the subject of in-service education and attendance shall be maintained by the agency and retained for one year.
(d) Job descriptions for every position, including volunteers involved in direct patient/family services, shall be established by the agency and shall include the position's qualifications and specific responsibilities. Hospice team member(s) shall be assigned only to duties that they are trained and competent to perform, or licensed to perform.
(e) Personnel records shall be established and maintained for hospice team members, including paid and direct patient/family services volunteers. These records shall be maintained for one year after employment or volunteer service ends. When requested by the State surveyors, the records shall be available on the agency premises for inspection by the Department. The records shall include:

(1) an application or resume that lists education, training, and previous employment, including job title;
(2) a job description with record of acknowledgment by the team member(s);
(3) reference checks or verification of previous employment;
(4) records of tuberculosis annual screening for hands-on care team members;
(5) documentation of Hepatitis B immunization or declination for hands-on care team members;
(6) bloodborne pathogen training for hands-on care team members, including annual updates, in compliance with 29 CFR 1910 and in accordance with the agency's exposure control plan;
(7) performance evaluations according to agency policy, or at least annually;
(8) verification of team member(s) credentials;
(9) records of the verification of competencies by agency supervisory personnel of skills required of hospice services personnel to carry out patient care tasks. The method of verification shall be defined in agency policy.

History Note: Authority G.S. 131E-202;
Eff. November 1, 1984;
Amended Eff. February 1, 1996; November 1, 1989;
Readopted Eff. January 1, 2021.

10A NCAC 13K .0402 INSERVICE EDUCATION AND TRAINING
(a) Written policies shall be established and implemented which include orientation, patient family volunteer training and inservice education for all hospice staff. Hospice residential facilities shall establish and implement a policy addressing hospice caregiver training. Attendance records on training shall be kept. Patient family care volunteers shall be required to meet the requirements of Rule .0401 of this Section. Training hours for patient family care volunteers shall include a minimum of 12 hours. Staff shall be required to participate in a minimum of eight hours included with other job specific training.
(b) Training for hospice staff, including patient family volunteers, providing direct patient and family services shall include, but not be limited to the following:

(1) an introduction to hospice;
(2) the patient family volunteer role in hospice care;
(3) concepts of death and dying;
(4) communication skills;
(5) care and comfort measures;
(6) diseases and medical conditions;
(7) psychosocial and spiritual issues related to death and dying;
(8) the concept of the hospice family;
(9) stress management;
(10) bereavement;
(11) infection control;
(12) safety;
(13) confidentiality; and
(14) patient rights.

(c) In addition to the training described in Paragraph (b) of this Rule, the following additional training shall be provided to hospice caregivers assigned to a hospice residential facility:

(1) training specific to the types of medications being administered when assisting the patient with self administration of medicines and provision of personal care from a curriculum approved by the Division of Health Service Regulation;

(2) orientation and instruction specific to the care needs of individual patients in the hospice residential facility; and

(3) notification criteria for licensed nursing staff as defined in the agency policies and procedures.

History Note: Authority G.S. 131E-202;
Eff. November 1, 1984;
Amended Eff. February 1, 1996; February 1, 1995; November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .0403 RESERVED FOR FUTURE CODIFICATION

SECTION .0500 - SCOPE OF SERVICES

10A NCAC 13K .0501 SERVICE REQUIREMENTS

The governing body shall ensure through policies and implemented procedures that the following services encompassing the essential elements of hospice care be provided, either directly by hospice personnel, or by contractual arrangement:

(1) Hospice nursing services, available 24 hours a day, by or under the supervision of a registered nurse; provided in accordance with the North Carolina Nurse Practice Act (G.S. 90, Article 9A) and the hospice care plan; and sufficient to ensure that nursing needs of each patient are met.

(a) Registered nurse duties include the following as a minimum:

(i) regularly assess the nursing needs of the hospice patient;

(ii) develop and implement the patient's hospice nursing care plan;

(iii) provide hospice nursing services, treatment, and diagnostic and preventive procedures;

(iv) initiate nursing procedures appropriate for the patient's hospice care and safety;

(v) observe signs and symptoms and report to the physician any unexpected changes in the patient's physical or emotional condition;

(vi) teach, supervise, and counsel the hospice patient and family members about providing care for the patient at home; and

(vii) supervise and train other nursing service personnel.

(b) Licensed practical nurse duties are delegated by and performed under the supervision of a registered nurse. Consistent with the hospice care plan, duties may include:

(i) participating in assessment of the patient's condition;

(ii) implementing nursing activities, including the administration of prescribed medical treatments and medications;

(iii) assisting in teaching the hospice patient and family members about providing care to the patient at home; and

(iv) delegating tasks to nurse aides and supervising their performance of tasks within the limitations established in 21 NCAC 36 .0225(d)(2) adopted by reference.

(c) The agency must retain current nursing on-call schedules and previous schedules for one year and make them available, on request, to the Department.

(2) Social work services which shall include, but not be limited to conducting an assessment of the psychosocial needs of the patient and family with the establishment of goals in the care plan to meet those needs; on-going counseling related to issues of death and dying to the patient and family as needed; and assisting the patient and family in the utilization of appropriate community resources.

(3) Spiritual counseling shall be offered to each hospice patient/family. The hospice shall assure that:

(a) no spiritual value or belief system is imposed on patients and families;

(b) a spiritual assessment is completed on each patient during the admission process; and

(c) a liaison and consultation is maintained with the patient family clergy or spiritual caregiver and other community based clergy or spiritual caregivers.

(4) Patient family volunteer services for a broad range of activities under the direction of the coordinator of patient family volunteers.

(5) Inpatient care services, for symptom management or respite care in a licensed hospital, nursing facility or licensed hospice inpatient facility, unless the hospice operates its own inpatient facility. The hospice shall assure that:

(a) a written agreement, is signed by both providers, which assures that the inpatient facility will provide care and services to hospice patients when necessary;

(b) the inpatient provider has policies consistent with the needs of hospice patients and their families and will, if necessary, modify policies such as visiting hour restrictions and routine tests, to meet those needs;

(c) the hospice monthly updated plan of care is furnished to the inpatient provider to ensure that the regimen established is followed as closely as feasible during the inpatient stay;

(d) all inpatient treatment and services are documented in the inpatient medical record and copy of the discharge summary retained as part of the hospice record; and

(e) effective transition from one type care to another be maintained with continuity of care being the primary goal.

(6) If the hospice provides or arranges for nurse aide services, those services shall be provided in accordance with physician's orders and interdisciplinary team care plan.

(a) Nurse aides shall only be assigned duties for which competence has been demonstrated and recorded in appropriate personnel records.

(b) Nurse aide duties may include, but are not limited to:

(i) providing or assisting with personal care, i.e. bathing, mouth care, hair and skin care;

(ii) checking vital signs and observing the patient's condition;

(iii) assisting with ambulation and limited, routine exercises.

(c) All nurse aide services shall be performed in accordance with a written assignment prepared by and under the supervision of the registered nurse. Supervision shall include a visit to the home by the nurse at least every two weeks, with or without the aide's presence, to assess the care and services provided. Documentation of supervisory visits shall be maintained in the medical record and include an assessment of the aide's performance in carrying out assigned duties and of the aide's relationship with the patient and family.

(7) Additional services shall be offered either directly by the hospice or by arrangement when ordered by the physician. These include physical therapy, occupational therapy, nutritional assessment and dietary counseling and other services as needed and ordered by the physician in accordance with the hospice plan of care.

(8) Bereavement counseling shall be offered to family members and others identified in the bereavement plan of care for a period of 12 months after the patient patient's death. The hospice shall assure that:

(a) an assessment of survivor risk factors is completed during the patient's admission to hospice and during the patient's illness;

(b) the bereavement care plan is established within six weeks after the patient's death;

(c) the bereavement care plan shall contain information about who shall receive bereavement services and what services will be offered;

(d) the bereavement care plan is reviewed quarterly at a minimum or more often as needed; and

(e) discharge from bereavement services before the 12 months expire is justified and documented.

History Note: Authority G.S. 131E-202;
Eff. November 1, 1984;
Amended Eff. February 1, 1996; June 1, 1991; November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .0502 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13K .0503 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13K .0504 HOME MEDICAL EQUIPMENT AND SUPPLIES

(a) The hospice shall make arrangements for obtaining any necessary supplies, equipment or prosthetic devices needed by the patient in the home, e.g., dressings, catheters, and oxygen. If the agency provides its own equipment and supplies, such services shall be in compliance with G.S. 90-85.22 unless exempted by the law.

(b) The agency shall have policies that address at a minimum:

- (1) Set-up, delivery, electrical safety and environmental requirements for equipment.
- (2) Proper cleaning and storage, preventive maintenance and repair according to manufacturer's guidelines.
- (3) Transportation, tracking and recall of equipment to meet all applicable regulatory requirements.
- (4) Emergency preparedness and backup of systems for equipment or power failure.
- (5) Patient instruction materials for each item of home medical equipment or supplies provided. Appropriate staff shall document the instruction.

History Note: Authority G.S. 131E-202;
Eff. November 1, 1984;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .0505 SERVICES ARRANGED WITH OTHER AGENCIES AND INDIVIDUALS

(a) When a hospice makes arrangements for the provision of services by other agencies and individuals; there shall be a written agreement, signed by both parties prior to the initiation of services, which includes the following:

- (1) the specific service to be provided;
- (2) the period of time the contract is to be in effect;
- (3) the availability of service;
- (4) the financial arrangements;
- (5) the provision for supervision of contracted personnel where applicable;
- (6) the verification that any individual providing services is appropriately licensed or registered as required by statute;
- (7) the assurance that individuals providing services under contractual arrangement meet the same requirements as found in this Subchapter for hospice staff;
- (8) the provision for the documentation of services provided in the patient's medical record; and
- (9) provision for the sharing of assessment and care plan data.

(b) All contracted services shall be provided in accordance with the orders of the attending physician and the care plan.

(c) The hospice shall assure that all contracted services are provided in accordance with the agreement. The agreement shall be reviewed annually and updated as needed.

(d) The hospice shall provide information and training as necessary on the hospice philosophy and concept of care to all agencies and individuals providing contracted services.

(e) Contract providers of direct patient care shall document services on the day of care, and shall submit, every two weeks at a minimum, records of all services provided within that timeframe.

History Note: Authority G.S. 131E-202;
Eff. November 1, 1984;
Amended Eff. February 1, 1996; November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

SECTION .0600 - PATIENT/FAMILY CARE

10A NCAC 13K .0601 ACCEPTANCE OF PATIENTS FOR HOSPICE SERVICES

A hospice shall implement and follow written policies governing the acceptance of patients which include at the minimum:

(1) Involvement of the interdisciplinary care team in making decisions regarding acceptance of patients and families and the designation of a primary caregiver.
(2) Initial assessment of the patient prior to acceptance to ensure that its resources are sufficient to meet the needs of the patient and family.
(3) Provision for a determination by the patient's physician that hospice care is appropriate and agreement to continue as the attending physician while the patient receives hospice services. All care and services provided shall be in accordance with the attending physician's written orders and the plan of care. Physician's orders shall be reviewed and signed by the physician at least every 90 days.
(4) Informed consent signed by the patient thereby agreeing to hospice services being provided.
(5) Advance notification of at least 48 hours to the patient or family when service provision is to be terminated, except in cases where the patient is in agreement with changes or there is a danger to a patient or staff member.
(6) Each patient or family accepted for hospice care shall receive written information pertaining to services available, including the means for contacting "on-call" personnel when needed and other information as necessary.

History Note: Authority G.S. 131E-202;
Eff. November 1, 1984;
Amended Eff. February 1, 1996; June 1, 1991; November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .0602 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13K .0603 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13K .0604 PATIENT'S RIGHTS AND RESPONSIBILITIES
(a) A hospice agency shall provide each patient with a written notice of the patient's rights and responsibilities in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of services. The agency shall maintain documentation showing that each patient has received a copy of his or her rights and responsibilities as defined in G.S. 131E-144.3.
(b) A hospice agency shall provide patients with a business hours telephone number for information, questions, or complaints about services provided by the agency. The agency shall also provide the Division of Health Service Regulation's complaints intake telephone numbers: within N.C. (800) 624-3004; outside of N.C. (919) 855-4500. The Division of Health Service Regulation shall investigate all allegations of non-compliance with the rules of this Subchapter.
(c) A hospice agency shall initiate an investigation within 72 hours of complaints made by a patient or his or her family. Documentation of both the existence of the complaint and the resolution of the complaint shall be maintained by the agency, for a minimum of one-year, in accordance with hospice agency policy and procedures.

History Note: Authority G.S. 131E-202;
Eff. February 1, 1996;
Readopted Eff. January 1, 2021.

10A NCAC 13K .0605 HOME CARE
If a hospice agency wishes to provide home care services as defined in G.S 131E-136 and meets the requirements of 10A NCAC 13J and the standards for the specific home care services applied for, the hospice agency may apply for a home care license. The licensure inspection shall be conducted either at the Department offices or on-site.

History Note: Authority G.S. 131E-202;
Eff. April 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

SECTION .0700 - PATIENT/FAMILY CARE PLAN

10A NCAC 13K .0701 CARE PLAN

(a) The agency shall develop and implement policies and procedures that ensure a written care plan is developed and maintained for each patient and family. The plan shall be established by the interdisciplinary team in accordance with the orders of the attending physician and be based on the assessment of the patient's and family's medical, psychosocial, and spiritual needs. The patient and family care coordinator shall have the primary responsibility for assuring the implementation of the patient's care plan. The care plan shall include the following:

(1) the patient's diagnosis and prognosis;
(2) the identification of problems or needs and the establishment of goals that are appropriate for the patient;
(3) the types and frequency of services required to meet the goals; and
(4) the identification of personnel and disciplines responsible for each service.

(b) The care plan shall be reviewed by the interdisciplinary team members and updated monthly. The interdisciplinary team and other personnel shall meet at a minimum every 15 days for the purpose of care plan review and staff support. Minutes shall be kept of these meetings that include the date, names of those in attendance, and the names of the patients discussed. Additionally, entries shall be recorded in the medical records of those patients whose care plans are reviewed.

History Note: *Authority G.S. 131E-202;*
Eff. November 1, 1984;
Amended Eff. February 1, 1996; November 1, 1989;
Readopted Eff. January 1, 2021.

10A NCAC 13K .0702 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13K .0703 RESERVED FOR FUTURE CODIFICATION

SECTION .0800 - PHARMACEUTICAL AND MEDICAL TREATMENT ORDERS AND ADMINISTRATION

10A NCAC 13K .0801 PHARMACEUTICAL AND MEDICAL TREATMENT ORDERS

(a) The hospice shall develop and implement written policies and procedures for the administration of drugs and treatments including controlled substances.

(b) The original order for drugs and treatments shall be signed by the attending physician and incorporated in the patient's medical record. Signed faxed orders are acceptable. The receiver of faxed orders shall assure a hard copy is incorporated in the patient record. Thermal paper faxes are not acceptable.

(c) Verbal orders shall be given to a licensed nurse, physician or other person authorized by state law to implement orders, recorded and signed by the person receiving it and countersigned by the prescribing physician, or person authorized by the North Carolina Medical Board to sign for another physician. Care may commence with a verbal order documented in the patient record.

(d) Changes in drugs and treatments shall be signed by the physician and incorporated in the medical record within 30 days.

(e) Each patient's drug regimen shall be monitored to assure optimal symptom control in accordance with physician's orders. Individuals qualified to perform such reviews are registered nurses, pharmacists, licensed physicians, nurse practitioners, and physician's assistants approved to practice in North Carolina.

History Note: *Authority G.S. 131E-202;*
Eff. November 1, 1984;
Amended Eff. April 1, 1996; November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .0802 ADMINISTRATION OF PHARMACEUTICALS

(a) In a private home, the administration of prescribed medications is the primary responsibility of the patient, family member or caregiver. Where special skills or knowledge are required, medication shall be administered by a

licensed registered nurse, licensed practical nurse with training specified by the North Carolina Board of Nursing, or physician.
(b) In a licensed hospice residence, medications shall be administered by a licensed nurse. Exceptions to this requirement are as follows:

(1) persons who hold statutory authority to administer medications;
(2) hospice patients, their families or caregivers who provide personal care to individuals whose health care needs are incidental to the personal care required;
(3) administration of oral nutritional supplements;
(4) applications of non-systemic, topical skin preparations which have local effects only provided that ongoing, periodic assessment of any skin lesion present is carried out by a person licensed to make such assessments; and
(5) administration of commonly used cleansing enema solutions or suppositories with local effects only.

(c) In a hospice inpatient unit or freestanding hospice inpatient facility, medications shall be administered by a licensed nurse, in accordance with the agency's, policies or in accordance with the contractual agreement between the hospice and the facility.
(d) The administration of all medications must be documented in the patient's record by the licensed nurse, including those medications administered by the licensed nurse and those administered by the patient family or, caregiver, as ordered by the physician.
(e) The provision of medications shall be specified in the agency's policies or in accordance with the contractual agreement between the hospice and the facility.
(f) A hospice agency or facility shall develop and implement written policies and procedures to govern the procurement, storage, administration and disposal of all drugs and biologicals in accordance with federal and state laws.
(g) Medications used in the home are the property of the patient and family and shall be appropriately stored. Hospice staff shall encourage disposal of unused or discontinued medications. Witnessed or reported disposal of medications shall be documented by hospice staff in the patient's record.
(h) If the agency maintains an emergency drug kit, handling shall be in accordance with the North Carolina Board of Pharmacy 21 NCAC 46 .1400.

History Note: *Authority G.S. 131E-202;*
Eff. November 1, 1984;
Amended Eff. February 1, 1996; June 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .0803 RESERVED FOR FUTURE CODIFICATION

SECTION .0900 - MEDICAL RECORDS

10A NCAC 13K .0901 CONTENT OF MEDICAL RECORD
(a) The hospice shall develop and implement policies and procedures to ensure that a medical record is maintained for each patient and is made available for licensure inspection. If the patient or responsible party wishes to deny the Department access to the medical record, that person shall sign a statement denying access. This statement shall be kept at the front of the record. If the patient is not able to approve or disapprove the release of such information for inspection, the patient's legal guardian shall make the decision and so indicate in writing.
(b) The record shall contain past and current medical and social data and include the following information:

(1) identification data (name, address, telephone, date of birth, sex, marital status);
(2) name of next of kin or legal guardian;
(3) names of other family members;
(4) religious preference and church affiliation and spiritual caregiver if appropriate;
(5) diagnosis, as determined by attending physician;
(6) authorization from attending physician for hospice care;
(7) source of referral;
(8) initial assessments, including physical, social, spiritual, environmental, and bereavement;
(9) consent for care form;

(10) physician's orders for drugs, treatments and other special care, diet, activity and other specific therapy services;
(11) care plan;
(12) clinical notes containing a record of all professional services provided directly or by contract with entries signed by the individual providing the services;
(13) nurse aide and hospice caregiver notes describing activities performed and pertinent observations;
(14) a copy of the signed patient's rights form or documentation of its delivery;
(15) patient family volunteer notes, as applicable, indicating type of contact, activities performed and time spent;
(16) discharge summary to include services provided, or reason for discharge if services are terminated prior to the death of the patient; and
(17) bereavement counseling notes.

History Note: Authority G.S. 131E-202;
Eff. November 1, 1984;
Amended Eff. April 1, 1996; February 1, 1995; November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .0902 RECORD CONTENT, HANDLING AND RETENTION

(a) The hospice agency shall develop and implement written policies governing the content, handling and retention of patient records.
(b) The agency shall maintain a patient record for each patient. Each page of the patient record shall have the patient's name. All entries in the record shall reflect the actual date of entry. Reference to any activity which occurred on a date prior to the date of entry shall be identified as a late or out of sequence entry. A system for maintaining originals and copies shall be described in the agency policies and procedures.
(c) The agency shall assure that originals of patient records are kept confidential and secure on the licensed premises unless in accordance with Rule .0209 of this Subchapter, or subpoenaed by a court of legal jurisdiction, or to conduct an evaluation as required in Rule .1001 of this Subchapter.
(d) If a record is removed to conduct an evaluation, the record shall be returned to the agency premises within five working days. The agency shall maintain a sign out log that includes to whom the record was released, patient's name and date removed.
(e) A copy of the patient record for each patient must be readily available to the hospice staff providing services or managing the delivery of such services.
(f) Patient records shall be retained for a period of not less than three years from the date of discharge of the patient, unless the patient is a minor in which case the record must be retained until five years after the patient's eighteenth birthday. If a minor patient dies, as opposed to being discharged for other reasons, the minor's records must be retained at least five years after the minor's death. When an agency ceases operation, the Department shall be notified in writing where the records will be stored for the required retention period.

History Note: Authority G.S. 131E-202;
Eff. November 1, 1984;
Amended Eff. February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

SECTION .1000 - EVALUATION

10A NCAC 13K .1001 EVALUATION REQUIRED

(a) The hospice shall develop and implement policies and a written plan for the implementation of a comprehensive assessment at least annually of its overall program and performance. The quality and appropriateness of care provided shall be assessed with the findings used to verify policy implementation, to identify problems and to establish problem resolution and policy revision as necessary.
(b) The hospice shall determine what individuals will carry out the evaluation. Representatives of the governing body, hospice staff, the interdisciplinary care team, and other appropriate professionals may be used.

(c) The evaluation shall include, as a minimum, a review of all policies and procedures and a medical record review.
(d) Documentation of the evaluation shall include the names and qualifications of the persons carrying out the evaluation, the criteria and methods used to accomplish it, and the action taken by the agency as a result of the findings.

History Note: *Authority G.S. 131E-202;*
Eff. November 1, 1984;
Amended Eff. February 1, 1996; November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .1002 RESERVED FOR FUTURE CODIFICATION

SECTION .1100 - HOSPICE RESIDENTIAL CARE

10A NCAC 13K .1101 ADMINISTRATION
(a) Hospice residences must conform to the rules outlined in 10A NCAC 13K .0100 through .1000.
(b) The hospice shall maintain administrative control of and responsibility for the provision of all services.
(c) The governing body shall have written policies and procedures governing the admission and delivery of all residential and inpatient hospice care services, including the management of medical and other emergencies.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .1102 HOSPICE RESIDENCE STAFFING
(a) There shall be trained hospice caregivers on duty 24 hours a day. A registered nurse shall be continuously available, for consultation and direct participation in nursing care. The registered nurse shall be on site when required to perform duties specified in the Nurse Practice Act. Supervision shall be provided by the Patient and Family Care Coordinator who may delegate this responsibility to the registered nurse on call.
(b) There shall be at least two staff on duty at all times.
(c) All staff, including patient family volunteers, counselors and clergy, shall complete training specific to dealing with the terminally ill and their families.
(d) Nurse aides employed to provide direct care shall be supervised by licensed nurses.
(e) Interdisciplinary team services shall be provided in accordance with the hospice plan of care.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, 1991;
Amended Eff. February 1, 1996; February 1, 1995;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .1103 PHARMACEUTICAL SERVICES
(a) The hospice shall establish and implement written policies and procedures to govern the procurement, storage, administration and disposal of all drugs and biologicals in accordance with federal and state laws.
(b) Pharmaceutical services shall be provided directly or through written agreement under the supervision of a licensed pharmacist and in accordance with Rule .0505 of this Subchapter. The pharmacist's duties shall include, but are not limited to the following:

(1) advising the hospice and the hospice interdisciplinary team on all matters pertaining to the procurement, storage, administration, disposal and record-keeping of drugs and biologicals; interactions of drugs; and counseling staff on appropriate and new drugs;
(2) inspecting all drug storage areas at least monthly;
(3) conducting patients' drug regimen reviews frequently enough to monitor symptom control, no less often than monthly, with appropriate recommendations to the physician and hospice staff.

(c) The hospice shall establish and implement written policies and procedures for drug control and accountability. Records of receipt and disposition of all controlled drugs shall be maintained for accurate reconciliation.
(d) Medications shall be labeled as described in the Pharmacy Laws of North Carolina.
(e) Medications must be stored in locked areas, at proper temperature, and accessible only to authorized persons in accordance with federal and state laws. Separately locked compartments must be provided for storage of controlled substances listed in the North Carolina Controlled Substances Act and other drugs subject to abuse.
(f) Controlled substances no longer needed by the patient are to be disposed of in compliance with the North Carolina Controlled Substances Act.
(g) The hospice shall maintain an emergency drug kit appropriate to the needs of the facility, assembled in consultation with the pharmacist and readily available for use. The pharmacist shall check and restock the kit as necessary, at least monthly, or more often if needed.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .1104 DIETARY SERVICES
(a) The hospice shall develop and maintain written policies and procedures for dietary services.
(b) Dietary services shall be provided directly or through written agreement with a food service company. Any written agreement shall meet the provisions of Rule .0505 of this Subchapter.
(c) The hospice shall offer the residents' favorite foods in their diets.
(d) The food service shall be planned and staffed to serve at least three meals throughout the day, timed to meet the needs of the residents. No more than 14 hours shall elapse between an evening meal which shall consist of three or more menu items, including a protein, and breakfast that includes a protein.
(e) The hospice shall appoint a staff member trained or experienced in nutrition care services to:
(1) plan menus to meet the nutritional needs of the residents; and
(2) supervise meal preparation and service.
(f) Therapeutic diets shall be prescribed by the physician and planned by a licensed dietitian/nutritionist or licensed nutritionist.
(g) Between-meal snacks from the basic food groups shall be offered and be available on a 24-hour basis.
(h) The procurement, storage, and refrigeration of food, refuse handling, and pest control shall comply with 15A NCAC 18A which are hereby incorporated by reference, including subsequent amendments, promulgated by the Commission for Public Health.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, 1991;
Readopted Eff. January 1, 2021.

10A NCAC 13K .1105 HOSPICE VISITATION
(a) The hospice shall:
(1) provide areas that ensure privacy for visitation and at the time of death;
(2) arrange for family members to remain with the patient overnight.
(b) Family and friends may visit at any hour. Children and pets shall not be excluded.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .1106 INFECTION CONTROL
(a) The hospice shall develop and implement an infection control program which shall aim to protect the residents, family and personnel from hospice or community associated infections.
(b) There shall be written policies and procedures governing the infection control program, developed by the hospice administrator and medical director and approved by the governing body.

(c) Universal precautions, as specified by the Centers for Disease Control (CDC), shall be defined in writing and strictly followed.
(d) All employees shall wear clean garments or protective clothing at all times and shall practice good personal hygiene and cleanliness.
(e) A procedure shall be developed whereby the implementation of the infection control program is monitored on a monthly basis.

History Note: Authority G.S. 131E-202;
Eff. June 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .1107 HOUSEKEEPING AND LINENS
(a) Requirements for linens and personal care articles shall include:
- (1) The use of common towels, washcloths, cups or any other personal care articles is prohibited.
- (2) Each resident shall have a supply of towels, washcloths and soap.
- (3) There shall be a supply of clean bed linens, towels, and washcloths.
- (4) There shall be a separate closed area for storage of clean linen.
- (5) Clean bed linens shall be changed as often as necessary, but no less than twice each week.
- (6) Mattress pads and pillows shall be of washable material.
- (7) There shall be separate storage for soiled linen and clothing. Such storage may consist of individual plastic bags or covered hampers or a soiled linen room. All personnel shall wash their hands thoroughly after handling soiled linen.
- (8) Laundry equipment shall be maintained in the facility or arrangements made with a commercial laundry to handle soiled linen.

(b) Housekeeping requirements are as follows:
- (1) Housekeeping practices and procedures shall be employed to keep the home free from offensive odors, and accumulations of dirt, rubbish and dust.
- (2) Cleaning shall be performed in a manner to minimize the spread of pathogenic organisms. Floors shall be cleaned regularly. Polishes on floors shall provide a non-skid finish; throw or scatter rugs shall not be used except for non-skid entrance mats.

History Note: Authority G.S. 131E-202;
Eff. June 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .1108 REPORT OF DEATH
The hospice shall have a written plan to be followed in case of patient death. The plan must provide for:
- (1) collection of data needed for the death certificate, as required by G.S. 130A-117;
- (2) recording time of death;
- (3) pronouncement of death;
- (4) notification of attending physician responsible for signing death certificate;
- (5) notification of next of kin or legal guardian;
- (6) authorization and release of body to funeral home; and
- (7) notification to the Department of any death resulting from an injury, accident, or other possible unnatural causes.

History Note: Authority G.S. 131E-202;
Eff. June 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .1109 RESIDENT CARE AREAS
(a) A facility shall meet the following requirements for resident bedrooms:

(1) private bedroom with not less than 100 square feet of floor area or semi-private bedroom with not less than 80 square feet of floor area per bed shall be provided;
(2) infants and small children shall not share a bedroom with an adult resident unless requested by the resident and families;
(3) each bedroom shall be furnished with a bed, a mattress protected by waterproof material, a mattress pad, a pillow, and one chair per resident;
(4) each bedroom shall be provided with one closet or wardrobe per bed. Each closet or wardrobe shall have clothing storage space of not less than 48 cubic feet per bed with one-half of this space for hanging clothes;
(5) each bedroom shall:
(A) be located at or above grade level;
(B) have provisions to ensure visual privacy for treatment or visiting; and
(C) be equipped with a towel rack for each resident;
(6) each bedroom shall provide lighting for treatment and non-treatment needs, 50 foot-candles for treatment needs, and 35 foot-candles for non-treatment needs; and
(7) no resident bedroom shall be accessed through a bathroom, kitchen, or another bedroom.

(b) A facility shall meet the following requirements for bathrooms:
(1) bathrooms shall be directly accessible to each resident bedroom without going through the general corridors. One bathroom may serve up to four residents. The bathroom doorway shall be a minimum 32-inch clear opening;
(2) each bathroom shall be furnished with the following:
(A) a toilet with grab bars;
(B) a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four inches in length. If the sink faucet depends on the building electrical service for operation, the faucet must have an emergency power source or battery backup capability. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;
(C) a mirror;
(D) soap, paper towel dispensers, and waste paper receptacle with a removable impervious liner; and
(E) a tub or shower.

(c) Each facility shall provide:
(1) an area for charting;
(2) storage provisions for personal effects of staff;
(3) storage areas for supplies and resident care equipment;
(4) storage area(s) for housekeeping equipment and cleaning supplies;
(5) a medication preparation area with a counter, a sink trimmed with valves that can be operated without hands, locked medication storage, and a double locked narcotic storage area under visual control of staff. If the sink is equipped with blade handles, the blade handles shall not be less than four inches in length. If the sink faucet depends on the building electrical service for operation, the faucet must have an emergency power source or battery backup capability. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;
(6) a lockable refrigerator for drug storage only or a separate locked box in a facility refrigerator. The refrigerator must be capable of maintaining a temperature range of 36 degrees F (2 degrees C) to 46 degrees F (8 degrees C);
(7) a kitchen with:
(A) a refrigerator;
(B) a cooking appliance ventilated to the outside;
(C) a 42-inch minimum double-compartment sink and domestic dishwashing machine capable of sanitizing dishes with 160 degrees F water; and
(D) storage space for non-perishables;
(8) a separate dining area measuring not less than 20 square feet per resident bed;
(9) a recreational and social activities area with not less than 150 square feet of floor area exclusive of corridor traffic;

(10) a nurses' calling system shall be provided:
   (A) in each resident bedroom for each resident bed. The call system activator shall be such that they can be activated with a single action and remain on until deactivated by staff at the point of origin. The call system activator shall be within reach of a resident lying on the bed. In rooms containing two or more call system activators, indicating lights shall be provided at each calling station;
   (B) nurses' calling systems that provide two-way voice communication shall be equipped with an indicating light at each calling station that lights and remains lighted as long as the voice circuit is operating;
   (C) a nurses' call emergency activator shall be provided at each residents' use toilet fixture, bath, and shower. The call system activator shall be accessible to a resident lying on the floor; and
   (D) calls shall register with the floor staff and shall activate a visible signal in the corridor at the resident's door. In multi-corridor units, additional visible signals shall be installed at corridor intersections; and
(11) heating and air conditioning equipment that can maintain a temperature range between 68 degrees and 80 degrees Fahrenheit, even upon loss of utility power.

History Note: Authority G.S. 131E-202;
Eff. June 1, 1991;
Amended Eff. February 1, 1995;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1110 FURNISHINGS

Furnishings of the residence shall be home-like and non-institutional and include lounge furniture in addition to furnishings in resident rooms. Accessories such as wallpaper, bedspreads, carpets and lamps shall be selected to create such an atmosphere. Provision shall be made for each resident to bring items from home to place about the room to the extent available space allows.

History Note: Authority G.S. 131E-202;
Eff. June 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .1111 HOSPICE RESIDENCE ZONING AND FIRE SAFETY REQUIREMENTS

Hospices maintained as residential facilities shall provide documentation of approval from local zoning commissions, fire departments and building departments.

History Note: Authority G.S. 131E-202;
Eff. June 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .1112 DESIGN AND CONSTRUCTION

(a) A new facility or remodeling of an existing facility shall meet the requirements of the North Carolina State Building Codes, which are incorporated by reference, including all subsequent amendments and editions, in effect at the time of licensure, construction, additions, alterations, or repairs. Copies of these codes may be purchased from the International Code Council online at https://shop.iccsafe.org/ at a cost of eight hundred fifty-eight dollars ($858.00) or accessed electronically free of charge at https://codes.iccsafe.org/codes/north-carolina. Existing licensed facilities shall meet the requirements of the North Carolina State Building Codes in effect at the time of licensure, construction, or remodeling.
(b) Each facility shall be planned, constructed, and equipped to support the services to be offered in the facility.
(c) Any existing building converted to a hospice facility shall meet all requirements of a new facility.
(d) The sanitation, water supply, sewage disposal, and dietary facilities shall meet the requirements of 15A NCAC 18A .1300, which is incorporated by reference including subsequent amendments.

History Note: Authority G.S. 131E-202;
Eff. June 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018;
Amended Eff. October 1, 2021.

10A NCAC 13K .1113 PLANS AND SPECIFICATIONS

(a) When construction or remodeling of a facility is planned, one copy of construction documents and specifications shall be submitted by the owner or the owner's appointed representative to the Department for review and approval. Schematic design drawings and design development drawings may be submitted for approval prior to the required submission of construction documents.
(b) Approval of construction documents and specifications shall be obtained from the Department prior to licensure. Approval of construction documents and specifications shall expire one year after the date of approval unless a building permit for the construction has been obtained prior to the expiration date of the approval of construction documents and specifications.
(c) If an approval expires, renewed approval shall be issued by the Department, provided revised construction documents and specifications meeting the standards established in Sections .1100 and .1200 of this Subchapter are submitted by the owner or owner's appointed representative and reviewed by the Department.
(d) Any changes made during construction shall require the approval of the Department to ensure compliance with the standards established in Sections .1100 and .1200 of this Subchapter.
(e) Completed construction or remodeling shall conform to the standards established in Sections .1100 and .1200 of this Subchapter. Construction documents and building construction, including the operation of all building systems, shall be approved in writing by the Department prior to licensure or patient and resident occupancy.
(f) The owner or owner's appointed representative shall notify the Department in writing either by U.S. Mail or e-mail when the construction or remodeling is complete.

History Note: Authority G.S. 131E-202;
Eff. June 1, 1991;
Amended Eff. February 1, 1996;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1114 PLUMBING

For hospice residential facilities with five or more residents, a 50-gallon quick recovery water heater is required. For hospice residential facilities with fewer than five residents, a 40-gallon quick recovery water heater is required.

History Note: Authority G.S. 131E-202;
Eff. June 1, 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1115 WASTE DISPOSAL

(a) Sewage shall be discharged into a public sewer system, or in the absence of a public sewer system, sewage shall be disposed of in a manner approved by the North Carolina Department of Health and Human Services, Division of Public Health, Environmental Health Section.
(b) Garbage and rubbish shall be stored in impervious containers in a manner as to prevent insect breeding and public health nuisances. Impervious containers with tight-fitting lids shall be provided and kept clean and in good repair. Garbage shall be removed from the outside storage at least once a week to a disposal site approved by the local health department having jurisdiction.
(c) The facility or unit shall take measures to keep insects, rodents, and other vermin out of the residential care facility. All openings to the outer air shall be protected against the entrance of flying insects by screens, closed doors, closed windows, or other means.

History Note: Authority G.S. 131E-202;
Eff. June 1, 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1116 APPLICATION OF PHYSICAL PLANT REQUIREMENTS

The physical plant requirements for each hospice residential facility or unit shall be applied as follows:

(1) New construction shall comply with all the requirements of this Section.

(2) Except where otherwise specified, existing buildings shall meet the licensure and code requirements in effect at the time of licensure, construction, alteration, or modification.

(3) Rules contained in this Section are minimum requirements and are not intended to prohibit buildings, systems, or operational conditions that exceed minimum requirements.

(4) The Division may grant an equivalency to allow alternate methods, procedures, design criteria, or functional variation from the requirements of this Rule and the rules contained in this Section. The equivalency may be granted by the Division when a governing body submits a written equivalency request to the Division that states the following:
   - (a) the rule citation and the rule requirement that will not be met because strict conformance with current requirements would be:
     - (i) impractical;
     - (ii) unable to be met due to extraordinary circumstances;
     - (iii) unable to be met due to new programs; or
     - (iv) unable to be met due to unusual conditions;
   - (b) the justification for the equivalency; and
   - (c) how the proposed equivalency meets the intent of the corresponding rule requirement.

(5) In determining whether to grant an equivalency request, the Division shall consider whether the request will reduce the safety and operational effectiveness of the facility. The governing body shall maintain a copy of the approved equivalence issued by the Division.

(6) Where rules, codes, or standards have any conflict, the more stringent requirement shall apply.

History Note: Authority G.S. 131E-202;
Eff. February 1, 1996;
Readopted Eff. October 1, 2021.

SECTION .1200 - HOSPICE INPATIENT CARE

10A NCAC 13K .1201 REQUIREMENTS FOR HOSPICE INPATIENT UNITS

(a) Hospice inpatient facilities or units shall conform to the rules outlined in Sections .0100 through .1100 of this Subchapter and the rules of this Section.

(b) Hospice inpatient units located in a licensed hospital shall meet the requirements of 10A NCAC 13B, which is incorporated by reference with subsequent amendments except for rules: 10A NCAC 13B .1912, .1919, .1922, and .1923.

(c) Hospice inpatient units located in a licensed nursing facility shall meet the requirements of 10A NCAC 13D, which is incorporated by reference with subsequent amendments.

History Note: Authority G.S. 131E-202;
Eff. June 1, 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1202 ADDITIONAL STAFFING REQUIREMENTS FOR HOSPICE INPATIENT UNITS

(a) All nursing services shall be provided under the supervision of a registered nurse.

(b) A facility providing respite care must provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient's plan of care. Each patient must receive all nursing services as prescribed by the physician and must be kept comfortable, clean, well-groomed and protected from accident, injury and infection. The presence of a Registered Nurse (RN) to provide direct care on all shifts is not required for patients receiving general inpatient care for respite unless specific nursing needs are in an individual patient's plan of care. If a patient in an inpatient facility is receiving general inpatient care for symptom management, then the 24-hour patient care RN staff must be available.

(c) Considerations for determining sufficiency of nursing personnel include:

(1) number of patients;

(2) specific patient care requirements;

(3) family care needs; and

(4) availability of support from other interdisciplinary team members.

(d) Hospice caregivers shall only provide care to patients in licensed hospice residential beds in a combined hospice inpatient and residential facility.

History Note: Authority G.S. 131E-202;
Eff. June 1, 1991;
Amended Eff. January 1, 2010; February 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .1203 ADDITIONAL SERVICES REQUIRED FOR HOSPICE INPATIENT CARE

(a) The hospice shall assure, directly or through written agreement, the provision of duly licensed radiology, laboratory, pathology and other medically related services in accordance with physicians' orders. Written agreement shall be in keeping with Rule .0505 of this Subchapter. If those services are provided directly, written policies and procedures shall govern their implementation.

(b) Radiology, laboratory and pathology services shall be under the direction of a physician qualified by education, training and experience to assume that function.

History Note: Authority G.S. 131E-202;
Eff. June 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018.

10A NCAC 13K .1204 ADDITIONAL PATIENT CARE AREA REQUIREMENTS FOR HOSPICE INPATIENT UNITS

(a) A facility shall meet the following requirements for patient bedrooms:

(1) private bedrooms shall be provided with not less than 100 square feet of floor area;

(2) semi-private bedrooms with not less than 80 square feet of floor area per bed; and

(3) floor space for closets, toilet rooms, vestibules, or wardrobes shall not be included in the floor areas required by this Paragraph.

(b) A facility shall meet the following requirements for dining, recreation, and common use areas:

(1) floor space for dining, recreation, and common use shall not be less than 30 square feet per bed;

(2) the dining, recreation, and common use areas required by this Paragraph may be combined; and

(3) floor space for physical and occupational therapy shall not be included in the areas required by this Paragraph.

(c) A facility shall meet the following requirements for toilet rooms, tubs, showers, and central bathing areas:

(1) a toilet room shall contain a toilet fixture and a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four inches in length. If the sink faucet depends on the building electrical service for operation, the faucet shall be connected to the essential electrical system. For the purposes of the rules of this Section, the "essential electrical system" means a system comprised of alternate sources of power and all connected distribution systems and ancillary equipment, designed to ensure continuity of electrical power to designated areas and functions of a facility during disruption of normal power sources, and also to minimize disruption within the internal wiring system as defined by the North Carolina State Building Codes: Electrical Code. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;

(2) if a sink is provided in each bedroom, the toilet room is not required to have a sink;

(3) a toilet room shall be accessible from each bedroom without going through the general corridors;

(4) one toilet room may serve two bedrooms, but not more than four beds; and

(5) a minimum of one central bathing area. In multi-level facilities, each patient floor shall contain a minimum of one central bathing area. Central bathing area(s) shall be provided with the following:

(A) wheelchair and stretcher accessible for staff to bathe a patient who cannot perform this activity independently;

(B) a bathtub, a manufactured walk-in bathtub, a similar manufactured bathtub designed for easy transfer of patients and residents into the tub, or a shower designed and equipped for

unobstructed ease of stretcher entry and bathing on three sides. Bathtubs shall be accessible on three sides. Manufactured walk-in bathtubs or a similar manufactured bathtub shall be accessible on two sides;

(C) a roll-in shower designed and equipped for unobstructed ease of shower chair entry and use. If a bathroom with a roll-in shower designed and equipped for unobstructed ease of shower chair entry adjoins each bedroom in the facility, the central bathing area is not required to have a roll-in shower;

(D) toilet fixture and lavatory; and

(E) an individual cubicle curtain enclosing each toilet, tub, and shower. A closed cubicle curtain at one of these plumbing fixtures shall not restrict access to the other plumbing fixtures.

(d) For each nursing unit on each floor, the following shall be provided:

(1) a medication preparation area with:

(A) a counter;

(B) a double locked narcotic storage area under the visual control of nursing staff;

(C) a medication refrigerator;

(D) medication storage visible by staff standing on the floor;

(E) cabinet storage; and

(F) a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four inches in length. If the sink faucet depends on the building electrical service for operation, the faucet shall be connected to the essential electrical system. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;

(2) a clean utility room with:

(A) a counter;

(B) storage; and

(C) a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four inches in length. If the sink faucet depends on the building electrical service for operation, the faucet shall be connected to the essential electrical system. If the sink has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;

(3) a soiled utility room with:

(A) a counter;

(B) storage; and

(C) a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four inches in length. If the sink faucet depends on the building electrical service for operation, the faucet shall be connected to the essential electrical system. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets. The soiled utility room shall be equipped for the cleaning and sanitizing of bedpans as required by 15A NCAC 18A .1312, which is incorporated by reference including subsequent amendments;

(4) a nurses' toilet and locker space for personal belongings;

(5) an audiovisual nurse-patient call system arranged to ensure that a patient's call in the facility notifies and directs staff to the location where the call was activated;

(6) a soiled linen storage room with a hand sanitizing dispenser. If the soiled linen storage room is combined with the soiled utility room, a separate soiled linen storage room is not required;

(7) a clean linen storage room provided in one or more of the following:

(A) a separate linen storage room;

(B) cabinets in the clean utility room; or

(C) a linen closet; and

(8) a janitor's closet.

(e) Dietary services and laundry each shall have a separate janitor's closet.

(f) Stretcher and wheelchair storage shall be provided.

(g) The facility shall provide storage at the rate of not less than five square feet of floor area per licensed bed. This storage space shall:

(1) be used by patients to store personal belongings and suitcases;
(2) be either in the facility or within 500 feet of the facility on the same site; and
(3) be in addition to the other storage space required by this Rule.

(h) Office space shall be provided for business transactions. Office space shall be provided for persons holding the following positions if these positions are provided:

(1) administrator;
(2) director of nursing;
(3) social services director;
(4) activities director; and
(5) physical therapist.

History Note: Authority G.S. 131E-202;
Eff. June 1, 1991;
Amended Eff. February 1, 1996;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1205 FURNISHINGS FOR HOSPICE INPATIENT CARE

(a) A facility shall provide handgrips at all toilet and bath facilities used by patients. Handrails shall be provided on both sides of all corridors where corridors are defined by walls and used by patients.

(b) For each nursing unit on each floor, the following shall be provided:

(1) a nourishment station separated from the nurses' station with:
  (A) work space;
  (B) cabinets;
  (C) refrigerated storage;
  (D) a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four inches in length. If the sink faucet depends on the building electrical service for operation, the faucet shall be connected to the essential electrical system. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets; and
  (E) a small stove, microwave, or hot plate; and
(2) a nurses' station with:
  (A) desk space for writing;
  (B) storage space for office supplies; and
  (C) storage space for patients' records.

(c) A facility shall provide flame resistant cubicle curtains in multi-bedded rooms.

History Note: Authority G.S. 131E-202;
Eff. June 1, 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1206 HOSPICE INPATIENT FIRE AND SAFETY REQUIREMENTS

(a) The hospice shall establish written policies and procedures governing disaster preparedness and fire protection.

(b) The hospice shall have detailed written plans and procedures to meet potential emergencies and disasters, including fire and severe weather.

(c) The plans and procedures shall be made available upon request to local or regional emergency management offices.

(d) The facility shall provide training for all employees in emergency procedures upon employment and annually.

(e) The facility shall conduct unannounced drills using the emergency procedures.

(f) The facility shall ensure that:

(1) the patients' environment remains as free of accident hazards as possible; and
(2) each patient receives adequate supervision and assistance to prevent accidents.

(g) The fire protection plan shall include:

(1) instruction for all personnel in use of alarms, firefighting equipment, methods of fire containment, evacuation routes, procedures for calling the fire department, and the assignment of specific tasks to all personnel in response to an alarm; and
(2) fire drills for each shift of personnel at least quarterly.

History Note: Authority G.S. 131E-202;
Eff. June 1, 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1207 HOSPICE INPATIENT REQUIREMENTS FOR HEATING/AIR CONDITIONING

A facility shall provide heating and cooling systems complying with the following:

(1) The American National Standards Institute and American Society of Heating, Refrigerating, and Air Conditioning Engineers Standard 170: Ventilation of Health Care Facilities, which is incorporated by reference, including all subsequent amendments and editions, and may be purchased for a cost of ninety-four dollars ($94.00) online at https://www.techstreet.com/ashrae/index.html. This incorporation does not apply to Section 9.1, Table 9-1 Design Temperature for Skilled Nursing Facility. The environmental temperature control systems shall be capable of maintaining temperatures in the facility at 71 degrees F. minimum in the heating season and a maximum of 81 degrees F. during non-heating season, even upon loss of utility power; and
(2) The National Fire Protection Association 90A: Standard for the Installation of Air-Conditioning and Ventilating Systems, which is incorporated by reference, including all subsequent amendments and editions, and may be purchased at a cost of fifty dollars and fifty cents ($50.50) from the National Fire Protection Association online at http://www.nfpa.org/catalog/ or accessed electronically free of charge at http://www.nfpa.org/aboutthecodes/AboutTheCodes.asp?DocNum=90A.

History Note: Authority G.S. 131E-202;
Eff. June 1, 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1208 HOSPICE INPATIENT REQUIREMENTS FOR EMERGENCY ELECTRICAL SERVICE

A facility shall provide an emergency electrical service for use in the event of failure of the normal electrical service. This emergency electrical service shall consist of the following:

(1) In any existing facility:
    (a) type 1 or 2 emergency lights as required by the North Carolina State Building Codes: Electrical Code;
    (b) additional emergency lights for all nurses' stations required by Rule .1205(b)(2) of this Section, medication preparation areas required by Rule .1204(d)(1) of this Section, storage areas, and for the telephone switchboard, if applicable;
    (c) one or more portable battery-powered lamps at each nurses' station; and
    (d) a source of emergency power for life-sustaining equipment, if the facility admits or cares for occupants needing such equipment, to ensure continuous operation with on-site fuel storage for a minimum of 72 hours.
(2) An emergency power generating set, including the prime mover and generator, shall be located on the premises and shall be reserved exclusively for supplying the essential electrical system.
(3) Emergency electrical services shall be provided as required by the North Carolina State Building Codes: Electric Code with the following modification: Section 517.10(B)(2) of the North Carolina State Building Codes: Electrical Code shall not apply to new facilities.
(4) The following equipment, devices, and systems that are essential to life safety and the protection of important equipment or vital materials shall be connected to the equipment branch of the essential electrical system as follows:
    (a) nurses' calling system;
    (b) fire pump, if installed;

(c) sewerage or sump lift pump, if installed;
(d) one elevator, where elevators are used for vertical transportation of patients;
(e) equipment such as burners and pumps necessary for operation of one or more boilers and their necessary auxiliaries and controls, required for heating and sterilization, if installed; and
(f) task illumination of boiler rooms, if applicable.

(5) The following equipment, devices, and systems that are essential to life safety and the protection of important equipment or vital materials shall be connected to the life safety branch of the essential electrical system as follows:
(a) alarm system, including fire alarm actuated at manual stations, water flow alarm devices of sprinkler systems if electrically operated, fire detecting and smoke detecting systems, paging or speaker systems if intended for issuing instructions during emergency conditions, and alarms required for nonflammable medical gas systems, if installed; and
(b) equipment necessary for maintaining telephone service.

(6) Where electricity is the only source of power normally used for the heating of space, an essential electrical system shall be provided for heating of patient rooms. Emergency heating of patient rooms shall not be required in areas where the facility is supplied by at least two separate generating sources or a network distribution system with the facility feeders so routed, connected, and protected that a fault any place between the generating sources and the facility will not likely cause an interruption of more than one of the facility service feeders.

(7) An essential electrical system shall be so controlled that after interruption of the normal electric power supply, the generator is brought to full voltage and frequency and connected within 10 seconds through one or more primary automatic transfer switches to all emergency lighting, alarms, and equipment necessary for maintaining telephone service. All other lighting and equipment required to be connected to the essential electrical system shall either be connected through the 10 second primary automatic transfer switching or shall be connected through delayed automatic or manual transfer switching. If manual transfer switching is provided, staff of the facility shall operate the manual transfer switch. Electrical outlets connected to the essential electrical system shall be marked for identification.

(8) Fuel shall be stored for the operation of the emergency power generator for a period not less than 72 hours, on a 24-hour per day operational basis with on-site fuel storage. The generator system shall be tested and maintained per National Fire Protection Association Health Care Facilities Code, NFPA 99, 2012 edition, which is incorporated by reference, including all subsequent amendments and editions. Copies of this code may be purchased at a cost of seventy-nine dollars and fifty cents ($79.50) from the National Fire Protection Association - online at http://www.nfpa.org/catalog/ or accessed electronically free of charge at http://www.nfpa.org/aboutthecodes/AboutTheCodes.asp?DocNum=99. The facility shall maintain records of the generator system tests and shall make these records available to the Division for inspection upon request.

(9) The electrical emergency service at existing facilities shall comply with the requirements established in this Rule in effect at the time a license is first issued. Any remodeling of an existing facility that results in changes to the emergency electrical service shall comply with the requirements established in this Rule in effect at the time of remodeling.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1209 HOSPICE INPATIENT REQUIREMENTS FOR GENERAL ELECTRICAL

(a) All main water supply shut off valves in the sprinkler system shall be electronically supervised so that if any valve is closed an alarm will sound at a continuously manned central station.
(b) No two adjacent emergency life safety branch lighting fixtures shall be on the same circuit.
(c) Receptacles in bathrooms shall have ground fault protection.
(d) Each patient bed location shall be provided with a minimum of eight single or four duplex receptacles.
(e) Each patient bed location shall be supplied by at least two branch circuits, one from the equipment branch and one from the normal system.

(f) The fire alarm system shall be installed to transmit an alarm automatically to the fire department that is legally committed to serve the area where the facility is located, by the direct and reliable method approved by local ordinances.
(g) In patient areas, fire alarms shall be gongs or chimes rather than horns or bells.

History Note: Authority G.S. 131E-202;
Eff. June 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018;
Amended Eff. October 1, 2021.

10A NCAC 13K .1210 OTHER HOSPICE INPATIENT REQUIREMENTS
(a) A nurses' calling system shall be provided:
(1) in each patient bedroom for each patient bed. The call system activator shall be such that it can be activated with a single action and remain on until deactivated by staff at the point of origin. The call system activator shall be within reach of a patient lying on the bed. In rooms containing two or more call system activators, indicating lights shall be provided at each calling station;
(2) nurses' calling systems that provide two-way voice communication shall be equipped with an indicating light at each calling station that lights and remains lighted as long as the voice circuit is operating;
(3) a nurses' call emergency activator shall be provided at each patients' use toilet fixture, bath, and shower. The call system activator shall be accessible to a patient lying on the floor; and
(4) calls shall register with the floor staff and shall activate a visible signal in the corridor at the patient's door. In multi-corridor units, additional visible signals shall be installed at corridor intersections.
(b) At least one telephone shall be available in each area where patients are admitted and additional telephones or extensions as are necessary to ensure availability in case of need.
(c) General outdoor lighting shall be provided to illuminate walkways and drive.

History Note: Authority G.S. 131E-202;
Eff. June 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, 2018;
Amended Eff. October 1, 2021.

10A NCAC 13K .1211 ADDITIONAL PLUMBING REQUIREMENTS/HOSPICE INPATIENT UNITS
Hospice inpatient facilities or units shall provide a flow of hot water within safety ranges specified as follows:
(1) Patient Areas – 6 ½ gallons per hour per bed and at a temperature of 100 to 116 degrees F;
(2) Dietary Services – 4 gallons per hour per bed and at a minimum temperature of 140 degrees F; and
(3) Laundry Area – 4 ½ gallons per hour per bed and at a minimum temperature of 140 degrees F.

History Note: Authority G.S. 131E-202;
Eff. June 1, 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1212 APPLICATION OF PHYSICAL PLANT REQUIREMENTS
The physical plant requirements for each hospice inpatient facility or unit shall be applied as follows:
(1) New construction shall comply with all the requirements of this Section.
(2) Except where otherwise specified, existing buildings shall meet the licensure and code requirements in effect at the time of licensure, construction, alteration, or modification.
(3) Rules contained in this Section are minimum requirements and are not intended to prohibit buildings, systems, or operational conditions that exceed minimum requirements.
(4) The Division may grant an equivalency to allow alternate methods, procedures, design criteria, or functional variation from the requirements of this Rule and the rules contained in this Section. The equivalency may be granted by the Division when a governing body submits a written equivalency request to the Division that states the following:

(a) the rule citation and the rule requirement that will not be met because strict conformance with current requirements would be:
(i) impractical;
(ii) unable to be met due to extraordinary circumstances;
(iii) unable to be met due to new programs; or
(iv) unable to be met due to unusual conditions;
(b) the justification for the equivalency; and
(c) how the proposed equivalency meets the intent of the corresponding rule requirement.
(5) In determining whether to grant an equivalency request, the Division shall consider whether the request will reduce the safety and operational effectiveness of the facility. The governing body shall maintain a copy of the approved equivalence issued by the Division.
(6) Where rules, codes, or standards have any conflict, the more stringent requirement shall apply.

History Note: *Authority G.S. 131E-202;*
Eff. February 1, 1996;
Readopted Eff. October 1, 2021.

SUBCHAPTER 13L - NURSING POOL LICENSURE

SECTION .0100 - GENERAL INFORMATION

10A NCAC 13L .0101 DEFINITIONS

The following definitions apply throughout this Subchapter:
(1) "Division" means the Division of Health Service Regulation within the Department of Health and Human Services.
(2) "Premises" means a building and the tract of land upon which it sits.

History Note: *Authority G.S. 131E-154.4;*
Eff. January 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SECTION .0200 - LICENSING

10A NCAC 13L .0201 APPLICATION FOR LICENSE

(a) Requests for a nursing pool license shall be submitted on application forms made available by the Division. Each application shall include the following information:
(1) Business identification consisting of the following:
(A) The business name or names under which the licensed services will be offered in brochures, yellow pages, and other advertisements.
(B) The full street address location of the office premises which the public will contact to obtain the offered nursing pool services.
(C) The postal address of the office for which licensing is requested.
(D) A listing or description of any state issued licenses applicable to the premises for which the application is submitted.
(2) Ownership disclosure consisting of the following:
(A) The name of the legal person, corporation, partnership, or proprietor, with ownership liability and authority applying for a license.
(B) The name, business title, address, and telephone number of the proprietor, managing partner, or chief executive officer.
(C) The name of other corporations, trusts, or holding companies involved when the applying entity is a wholly owned subsidiary corporation.
(3) Names, title and telephone number of the on-site manager for the location to be licensed.

(4) General information on all health care related services expected to be offered to the public from the premises on the effective date of licensure.

(b) Nursing pools subject to this Subchapter, but exempt from separate licensure, shall submit an application in accordance with this Rule and an addendum to their existing license shall be issued.

(c) A copy of this Subchapter together with the governing statutes shall be maintained on the licensed premises for use by on-site personnel.

History Note: Authority G.S. 131E-154.4;
Eff. January 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 13L .0202 ISSUANCE OF LICENSE

(a) Each site shall be individually licensed when it has been determined by the Division that the site involved is substantially in compliance with this Subchapter. Business sites using the same public business name already licensed by the Division pursuant to G.S. 131E, Articles 5 or 6 shall have "nursing pool" added to their existing license.

(b) Nursing pools administered by health care facilities as defined in G.S. 131E-154.2 of the Nursing Pool Licensure Act, and agencies licensed under Article 5 or 6 of Chapter 131E of the General Statutes and not required to be separately licensed may request the issuance of a license as a more visible means of demonstrating their compliance with the provisions of this Subchapter.

(c) All licenses shall be renewed every two years.

History Note: Authority G.S. 131E-154.3; 131E-154.4; 131E-154.5;
Eff. January 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 13L .0203 PROGRAM COMPLIANCE

(a) The Division shall employ a system of initial and renewal applications, complaint investigation and on-site inspections for nursing pools with sites in the state as a means for monitoring and determining program compliance. This system shall be applied uniformly to all licensed and license-exempt nursing pool premises. Routine licensing renewal activities may be conducted by mail. Licensing of nursing pools with sites outside the state, but which provide personnel to health care facilities within the state, shall be conducted by mail.

(b) In the event of non-compliance with any rule or rules in this Subchapter or the Nursing Pool Licensure Act, the business shall be given no more than thirty days, the specific time period to be determined by the Division, to correct the non-compliance.

(c) The Division may suspend, revoke, annul, withdraw, recall, cancel, or amend a license in accordance with G.S. 131E-154.6 for any nursing pool that substantially fails to comply with the rules contained in this Subchapter or that fails to implement an approved plan of correction for violations of rules cited by the Division. A nursing pool may appeal any adverse decision made by the Division concerning its license by making such appeal in accordance with the Administrative Procedure Act, G.S. 150B and departmental rules 10A NCAC 01 et seq. As provided for in G.S. 131E-154.7, the Division may seek injunctive relief to prevent a person from establishing or operating a nursing pool without a license.

History Note: Authority G.S. 131E-154.4;
Eff. January 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 13L .0204 PUBLIC DISPLAY

(a) The nursing pool's license shall be valid only for the premises on which displayed and specified on the license.

(b) The public use of the pool's license status shall not be included in any advertisement which involves any unlicensed services offered by the licensee and has the potential for misleading the public into believing that both covered and non-covered services are represented by the license.

History Note: Authority G.S. 131E-154.3; 131E-154.4;
Eff. January 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SECTION .0300 - ADMINISTRATION

10A NCAC 13L .0301 WRITTEN POLICIES AND PROCEDURES
(a) The nursing pool shall have written administrative and personnel policies to govern the services that it provides. These policies shall include those concerning patient care, personnel, training and orientation, supervision, employee evaluation, and organizational structure.
(b) At the option of the licensee, written policies and procedures may address other services not subject to the Nursing Pool Licensure Act. The Division shall not require separate policies and procedures if the premises from which nursing pool services are offered also offers additional temporary nursing services not subject to licensure.
(c) Policies shall provide that no reprisal action shall be taken against any employee who reports instances of patient rights violations or patient abuse, neglect, or exploitation to the appropriate governmental authority.
(d) The nursing pool shall retain all administrative records for five years and shall make these records available to the Division upon request. Administrative records shall include:
(1) documents evidencing control and ownerships, such as corporation or partnership papers;
(2) policies and procedures governing the operation of the agency;
(3) minutes of the agency's professional and administrative staff meetings;
(4) reports of complaints, inspections, reviews, and corrective actions taken related to licensure; and
(5) contracts and agreements to which the agency is a party.

History Note: Authority G.S. 131E-154.4;
Eff. January 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015;
Amended Eff. April 1, 2024.

10A NCAC 13L .0302 PERSONNEL RECORDS
(a) A nursing pool shall maintain a personnel record on each individual.
(b) Each individual's personnel record shall include:
(1) A legible copy of an unexpired license verification to practice nursing as a registered nurse or a licensed practical nurse or an unexpired Nurse Aide I or Nurse Aide II listing verification.
(2) A completed job application with employment history, training, education, continuing education, and identification data including name, address, and telephone number.
(3) Results of reference checks.
(4) Performance evaluations annually. The annual performance evaluation shall include feedback from the health care facility of the on-site performance of contracted nursing personnel.
(c) Personnel records shall be maintained for one year after termination from agency employment.

History Note: Authority G.S. 131E-154.4;
Eff. January 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015;
Amended Eff. April 1, 2024.

10A NCAC 13L .0303 INSURANCE REQUIRED
The nursing pool shall carry general and professional liability insurance written by an insurer approved by the North Carolina Department of Insurance. The terms of such insurance shall be disclosed to clients receiving services from the licensee.

History Note: Authority G.S. 131E-154.4;
Eff. February 1, 1991;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SUBCHAPTER 13M - MAMMOGRAM AND PAP SMEAR CERTIFICATION

SECTION .0100 - PAP SMEAR CERTIFICATION

10A NCAC 13M .0101 STATE CERTIFICATION FOR LABORATORIES CONDUCTING PAP SMEARS

(a) All laboratories evaluating Pap smears shall be state certified by the Division of Health Service Regulation, Department of Health and Human Services, in accordance with this Rule.
(b) To be state certified, all laboratories shall be licensed under the federal Clinical Laboratory Improvement Act as amended or certified by the Centers for Medicare and Medicaid Services for the specialty of cytology.
(c) To be state certified, laboratories shall perform Pap smear examinations only on specimens submitted by a health care provider whose scope of practice includes the function of taking Pap smears.
(d) An application for state certification shall be submitted to the Division of Health Service Regulation listing the name and location of the laboratory requesting certification, the name of the laboratory director and evidence that the laboratory meets the requirements listed in Paragraphs (b) and (c) of this Rule. Laboratories will be notified in writing within 45 days of the receipt of the application that they have been certified or, if certification has been denied, of the reasons for denial.
(e) State certification must be renewed by a facility when licensing or certification renewal is required by the program that established state certification eligibility pursuant to Paragraph (b) of this Rule.
(f) If a laboratory's license or certification for one of these programs is suspended or revoked, the laboratory director shall immediately notify the Division of Health Service Regulation and the laboratory's state certification under this Rule shall be revoked. The laboratory may apply for recertification when it can provide evidence that it meets the requirements listed in Paragraphs (a) - (e) of this Rule.
(g) Appeals of the Division's decisions regarding state certification shall be in accordance with the Administrative Procedures Act, G.S. 150B.

History Note: *Authority G.S. 143B-165;*
Temporary Adoption Eff. October 11, 1991 For a Period of 141 Days to Expire on February 29, 1992;
Eff. March 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SECTION .0200 - MAMMOGRAPHY CERTIFICATION

10A NCAC 13M .0201 STATE CERTIFICATION OF SCREENING MAMMOGRAPHY SERVICES

(a) All facilities performing screening mammograms shall be state certified by the Division of Health Service Regulation, Department of Health and Human Services in accordance with this Rule.
(b) To be state certified, all equipment used in the performance of screening mammography shall be dedicated to such use by manufacturer's design. Each piece of mammography X-ray equipment, whether located in a fixed or mobile facility, shall be maintained in a safe operating condition and shall be registered and used in accordance with the Rules in 15A NCAC 11.
(c) To be state certified, all facilities shall be certified by the Centers for Medicare and Medicaid Services or shall be accredited by the American College of Radiology for the performance of mammography screening.
(d) An application for state certification shall be submitted to the Division of Health Service Regulation listing the name and location of the facility requesting certification, the name of the owner, and evidence that the facility meets the requirements listed in Paragraphs (b) and (c) of this Rule. Facilities shall be notified in writing within 45 days of the receipt of the application that they have been certified or, if certification has been denied, of the reasons for denial.
(e) State certification must be renewed by a facility when certification or accreditation renewal is required by the program that established state certification eligibility pursuant to Paragraph (c) of this Rule.

(f) If a facility's certification or accreditation for one of these programs is suspended or revoked, the facility operator shall immediately notify the Division of Health Service Regulation and the facility's state certification under this Rule shall be revoked. The facility may apply for recertification when it can provide evidence that it meets the requirements listed in Paragraphs (a) - (e) of this Rule.
(g) The North Carolina Medical Care Commission delegates the authority to grant waivers of this Rule to the Division of Health Service Regulation. The Commission, however, shall review all waivers granted at its next regularly scheduled meeting and shall make any revisions to waivers deemed necessary at that time.
(h) In order to be granted a waiver of this Rule, a facility shall make a request for a waiver in writing to the Division of Health Service Regulation providing the following:

(1) justification that the rule should not be applied as written, because strict application would cause undue hardship;
(2) justification that adequate standards assuring early detection of breast cancer and affording protection of health and safety exist and will be met in lieu of the exact requirements;
(3) justification that the purpose of this Rule is met through equivalent standards affording equivalent protection of health and safety;
(4) information on the number of screening mammograms performed monthly for the previous six months;
(5) information proving that there is no state certified facility nearby by identifying the nearest state certified facility and providing information regarding the accessibility of mobile units in the area; and
(6) a plan for meeting standards necessary for certification, including the time required to meet standards.

(i) The Division of Health Service Regulation may grant a waiver to the extent that the factors listed in Paragraph (h) of this Rule are satisfied.
(j) Appeals of the Division's decisions regarding state certification shall be in accordance with the Administrative Procedures Act, G.S. 150B.

History Note: *Authority G.S. 143B-165;*
Temporary Adoption Eff. October 11, 1991 For a Period of 141 Days to Expire on February 29, 1992;
Eff. March 1, 1992;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SUBCHAPTER 13N – RESERVED FOR FUTURE CODIFICATION

SUBCHAPTER 13O – HEALTHCARE PERSONNEL REGISTRY

SECTION .0100 - HEALTH CARE PERSONNEL REGISTRY

10A NCAC 13O .0101 DEFINITIONS

The following definitions shall apply throughout this Subchapter:

(1) "Abuse" is defined by 42 CFR Part 488 Subpart E which is incorporated by reference, including subsequent amendments. Copies of the Code of Federal Regulations may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington D.C. 20402.
(2) "Diversion of drugs" means the unauthorized taking or use of any drug.
(3) "Drug" means any chemical compound that may be used on or administered to humans or animals as an aid in the diagnosis, treatment or prevention of disease or other condition or for the relief of pain or suffering or to control or improve any physiological pathologic condition.
(4) "Finding" (when used in conjunction with the Health Care Personnel Registry) means a determination by the Department that an allegation of resident abuse or neglect, misappropriation of resident or health care facility property, diversion of drugs belonging to a resident or health care facility, and fraud against a resident or health care facility has been substantiated.

(5) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State Law.
(6) "Health Care Facility" means all the facilities and agencies as defined in G.S. 131E-256(b).
(7) "Health Care Personnel" means all the persons as defined in G.S. 131E-256(c).
(8) "Misappropriation of resident property" is defined by 42 CFR Part 488 Subpart E which is incorporated by reference, including subsequent amendments. Copies of the Code of Federal Regulations may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington D.C. 20402.
(9) "Misappropriation of the property of a health care facility" means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a health care facility's property without the facility's consent.
(10) "Neglect" is defined by 42 CFR Part 488 Subpart E which is incorporated by reference, including subsequent amendments. Copies of the Code of Federal Regulations may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington D.C. 20402.
(11) "Resident" means all the individuals residing in or being served by a health care facility as defined in G.S. 131E-256(b).

History Note: *Authority G.S. 131E-256; 42 U.S.C. 1395; 42 U.S.C. 1396;*
Temporary Adoption Eff. December 20, 1996;
Eff. August 1, 1998;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL

The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).

History Note: *Authority G.S. 131E-256;*
Temporary Adoption Eff. December 20, 1996;
Eff. August 1, 1998;
Amended Eff. April 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SECTION .0200 – MEDICATION AIDE REGISTRY

10A NCAC 13O .0201 MEDICATION AIDE COMPETENCY EVALUATION

(a) A competency evaluation candidate shall be advised by the Department after successful completion of a North Carolina Board of Nursing approved medication aide training program and prior to the competency exam that upon successful completion of the competency exam the individual will be listed on the State's medication aide registry.
(b) The competency exam shall include each course requirement specified in the North Carolina Board of Nursing's approved training program as provided for in 21 NCAC 36 .0403 and 21 NCAC 36 .0406.
(c) The competency examination shall be administered and evaluated only by the Department or its agent.
(d) A record of successful completion of the competency exam shall be included in the medication aide registry within 30 business days of successful completion of the evaluation.
(e) If the competency exam candidate does not satisfactorily complete the exam, the candidate shall be advised by the Department of the areas which the individual did not pass.
(f) Every competency exam candidate shall have the opportunity to take the exam three times before being required to retake and successfully complete the Medication Aide training program.

History Note: *Authority G.S. 131E-114.2(b); 131E-270;*
Eff. October 1, 2006;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

10A NCAC 13O .0202 REGISTRY OF MEDICATION AIDES

(a) Prior to assigning medication aide duties to a Medication Aide, pursuant to G.S. 131E-114.2, the facility shall conduct a clinical skills validation for those medication administration tasks to be performed in the facility. This validation shall be conducted by a registered nurse consistent with his/her occupational licensing law and who has a current unencumbered license to practice in North Carolina. A record of this validation shall be retained in the Medication Aide's file.

(b) The Department shall provide information on the registry within one business day of the request for information.

(c) The medication aide listing on the Medication Aide Registry shall be renewed every two years provided the individual has worked for a minimum of eight hours as a Medication Aide in each consecutive 24 month period following their initial listing.

(d) The registry shall contain the following information for each individual who is listed on the Medication Aide Registry:

- (1) the individual's full name;
- (2) the date the individual became eligible for placement on the registry;
- (3) the training program and competency exam completed; and
- (4) the date of listing renewal and expiration.

(e) The Medication Aide Registry shall remove entries for individuals who have not been employed as a medication aide for a minimum of eight hours in each consecutive 24 month period following initial listing.

(f) An individual who gains or attempts to gain registry listing by providing false or misleading information on listing or re-listing applications shall not be listed on the registry.

History Note: *Authority G.S. 131E-114.2(b); 131E-270;*
Eff. October 1, 2006;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, 2015.

SECTION .0300 - NURSE AIDE I REGISTRY

10A NCAC 13O .0301 NURSE AIDE I TRAINING AND COMPETENCY EVALUATION

(a) To be eligible to be listed on the NC Nurse Aide I Registry by the Health Care Personnel Education and Credentialing Section, a person shall:

- (1) pass a Nurse Aide I training program approved by the Department in accordance with 42 CFR 483.151 through 42 CFR 483.152 and the State of North Carolina's Nurse Aide I competency exam; or
- (2) apply to the Department for approval to be listed on the NC Nurse Aide I Registry by reciprocity of a nurse aide certification or registration from another State to North Carolina.

(b) In applying for reciprocity of a nurse aide certification or registration to be listed on the NC Nurse Aide I Registry pursuant to Subparagraph (a)(2) of this Rule, the applicant shall:

- (1) submit a completed application to the Department that includes the following:
  - (A) first, middle, and last name;
  - (B) the applicant's prior name(s), if any;
  - (C) mother's maiden name;
  - (D) gender;
  - (E) social security number;
  - (F) date of birth;
  - (G) mailing address;
  - (H) email address;
  - (I) home telephone number;
  - (J) any other State registries of nurse aides upon which the applicant is listed;
  - (K) certification or registration numbers for any State nurse aide registries identified in Part (b)(1)(J) of this Rule;
  - (L) original issue dates for any certifications or registrations identified in Part (b)(1)(K) of this Rule;

(M) expiration dates for any certifications or registrations identified in Part (b)(1)(K) of this Rule; and

(N) employment history;

(2) provide documentation verifying that his or her registry listing is active and in good standing in the State(s) of reciprocity, dated no older than 30 calendar days prior to the date the application is received by the Department; and

(3) provide a copy of his or her Social Security card and an unexpired government-issued identification containing a photograph and signature.

(c) For the applicant to be approved for reciprocity of a nurse aide certification or registration and be listed on the NC Nurse Aide I Registry, the Department shall verify the following:

(1) the applicant has completed an application in accordance with Subparagraph (b)(1) of this Rule;

(2) the applicant is listed on another State's registry of nurse aides as active and in good standing;

(3) the applicant has no pending or substantiated findings of abuse, neglect, exploitation, or misappropriation of resident or patient property recorded on other State registries of nurse aides;

(4) if the applicant has been employed as a nurse aide for monetary compensation consisting of at least a total of eight hours of time worked performing nursing or nursing-related tasks delegated and supervised by a Registered Nurse, then the applicant shall provide the employer name, employer address, and dates of employment for the previous 24 consecutive months;

(5) the name listed on the Social Security card and government-issued identification containing a photograph and signature submitted with the application matches the name listed on another State's registry of nurse aides or that the applicant has submitted additional documentation verifying any name changes; and

(6) the applicant completed a State-approved nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152 or a State-approved competency evaluation program that meets the requirements of 42 CFR 483.154.

(d) The Department shall within 10 business days of receipt of an application for reciprocity of a nurse aide certification or registration or receipt of additional information from the applicant:

(1) inform the applicant by letter whether he or she has been approved; or

(2) request additional information from the applicant.

The applicant shall be added to the NC Nurse Aide I Registry within three business days of Department approval.

(e) This Rule incorporates 42 CFR Part 483 Subpart D by reference, including all subsequent amendments and editions. Copies of the Code of Federal Regulations may be accessed electronically free of charge from www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR.

(f) The State of North Carolina's Nurse Aide I competency exam shall include each course requirement specified in the Department-approved Nurse Aide I training program as provided for in 42 CFR 483.152.

(g) The State of North Carolina's Nurse Aide I competency exam shall be administered and evaluated only by the Department or its contracted testing agent as provided for in 42 CFR 483.154.

(h) The Department shall include a record of completion of the State of North Carolina's Nurse Aide I competency exam in the NC Nurse Aide I Registry within 30 days of passing the written or oral exam and the skills demonstration as provided for in 42 CFR 483.154.

(i) If the State of North Carolina's Nurse Aide I competency exam candidate does not pass the written or oral exam and the skills demonstration as provided for in 42 CFR 483.154, the candidate shall be advised by the Department of the areas that the individual did not pass.

(j) Every North Carolina's Nurse Aide I competency exam candidate shall have the opportunity to take the exam at maximum three times before being required to retake and pass a Nurse Aide I training program.

(k) U.S. military personnel who have completed medical corpsman training and retired or non-practicing nurses shall not be required to take the Department-approved Nurse Aide I training program to be listed or relisted on the Nurse Aide I Registry, unless the person fails to pass the State of North Carolina's Nurse Aide I competency exam after three attempts.

History Note: *Authority G.S. 131E-255; 42 CFR 483.150; 42 CFR 483.151; 42 CFR 483.152; 42 CFR 483.154; 42 CFR 483.156; 42 CFR 483.158;*
Eff. January 1, 2016;
Emergency Amendment Eff. April 20, 2020;
Temporary Amendment Eff. June 26, 2020;
Amended Eff. April 1, 2021.

SUBCHAPTER 13P – EMERGENCY MEDICAL SERVICES AND TRAUMA RULES

SECTION .0100 – DEFINITIONS

10A NCAC 13P .0101 ABBREVIATIONS

As used in this Subchapter, the following abbreviations mean:

(1) ACS: American College of Surgeons;
(2) AEMT: Advanced Emergency Medical Technician;
(3) AHA: American Heart Association;
(4) ASTM: American Society for Testing and Materials;
(5) CAAHEP: Commission on Accreditation of Allied Health Education Programs;
(6) CPR: Cardiopulmonary Resuscitation;
(7) ED: Emergency Department;
(8) EMD: Emergency Medical Dispatcher;
(9) EMDPRS: Emergency Medical Dispatch Priority Reference System;
(10) EMR: Emergency Medical Responder;
(11) EMS: Emergency Medical Services;
(12) EMS-NP: EMS Nurse Practitioner;
(13) EMS-PA: EMS Physician Assistant;
(14) EMT: Emergency Medical Technician;
(15) FAA: Federal Aviation Administration;
(16) FCC: Federal Communications Commission;
(17) ICD: International Classification of Diseases;
(18) ISS: Injury Severity Score;
(19) NHTSA: National Highway Traffic Safety Administration;
(20) OEMS: Office of Emergency Medical Services;
(21) OR: Operating Room;
(22) PSAP: Public Safety Answering Point;
(23) RAC: Regional Advisory Committee;
(24) RFP: Request For Proposal;
(25) SCTP: Specialty Care Transport Program;
(26) STEMI: ST Elevation Myocardial Infarction; and
(27) US DOT: United States Department of Transportation.

History Note: *Authority G.S. 143-508(b);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

10A NCAC 13P .0102 DEFINITIONS

In addition to the definitions in G.S. 131E-155, the following definitions apply throughout this Subchapter:

(1) "Affiliated EMS Provider" means the firm, corporation, agency, organization, or association identified with a specific county EMS system as a condition for EMS Provider Licensing as required by Rule .0204 of this Subchapter.
(2) "Affiliated Hospital" means a non-trauma center hospital that is owned by the Trauma Center or a hospital with a contract or other agreement to allow for the acceptance or transfer of the Trauma Center's patient population to the non-trauma center hospital.
(3) "Affiliate" or "Affiliation" means a reciprocal agreement and association that includes active participation, collaboration, and involvement in a process or system between two or more parties.

(4) "Alternative Practice Setting" means a practice setting that utilizes credentialed EMS personnel that may not be affiliated with or under the oversight of an EMS System or EMS System Medical Director.

(5) "Air Medical Ambulance" means an aircraft configured and medically equipped to transport patients by air. The patient care compartment of air medical ambulances shall be staffed by medical crew members approved for the mission by the Medical Director.

(6) "Air Medical Program" means a SCTP or EMS System utilizing rotary-wing or fixed-wing aircraft configured and operated to transport patients.

(7) "Assistant Medical Director" means a physician, EMS-PA, or EMS-NP who assists the Medical Director with the medical aspects of the management of a practice setting utilizing credentialed EMS personnel or medical crew members.

(8) "Bypass" means a decision made by the patient care technician to transport a patient from the scene of an accident or medical emergency past a receiving facility for the purposes of accessing a facility with a higher level of care, by a hospital of its own volition to reroute a patient from the scene of an accident or medical emergency or referring hospital to a facility with a higher level of care.

(9) "Community Paramedicine" means an EMS System utilizing credentialed personnel who have received additional training as determined by the EMS System Medical Director to provide knowledge and skills for the community needs beyond the 911 emergency response and transport operating guidelines defined in the EMS System plan.

(10) "Contingencies" mean conditions placed on a designation that, if unmet, may result in the loss or amendment of a designation.

(11) "Convalescent Ambulance" means an ambulance used on a scheduled basis solely to transport patients having a known non-emergency medical condition. Convalescent ambulances shall not be used in place of any other category of ambulance defined in this Subchapter.

(12) "Deficiency" means the failure to meet essential criteria for a designation that can serve as the basis for a focused review or denial of a designation.

(13) "Department" means the North Carolina Department of Health and Human Services.

(14) "Diversion" means the hospital is unable to accept a patient due to a lack of staffing or resources.

(15) "Educational Medical Advisor" means the physician responsible for overseeing the medical aspects of approved EMS educational programs.

(16) "EMS Care" means all services provided within each EMS System by its affiliated EMS agencies and personnel that relate to the dispatch, response, treatment, and disposition of any patient.

(17) "EMS Educational Institution" means any agency credentialed by the OEMS to offer EMS educational programs.

(18) "EMS Non-Transporting Vehicle" means a motor vehicle operated by a licensed EMS provider dedicated and equipped to move medical equipment and EMS personnel functioning within the scope of practice of an AEMT or Paramedic to the scene of a request for assistance. EMS nontransporting vehicles shall not be used for the transportation of patients on the streets, highways, waterways, or airways of the state.

(19) "EMS Peer Review Committee" means a committee as defined in G.S. 131E-155(6b).

(20) "EMS Provider" means those entities defined in G.S. 131E-155(13a) that hold a current license issued by the Department pursuant to G.S. 131E-155.1.

(21) "EMS System" means a coordinated arrangement of local resources under the authority of the county government (including all agencies, personnel, equipment, and facilities) organized to respond to medical emergencies and integrated with other health care providers and networks including public health, community health monitoring activities, and special needs populations.

(22) "Essential Criteria" means those items that are the requirements for the respective level of trauma center designation (I, II, or III), as set forth in Rule .0901 of this Subchapter.

(23) "Focused Review" means an evaluation by the OEMS of corrective actions to remove contingencies that are a result of deficiencies following a site visit.

(24) "Ground Ambulance" means an ambulance used to transport patients with traumatic or medical conditions or patients for whom the need for specialty care, emergency, or non-emergency medical care is anticipated either at the patient location or during transport.

(25) "Hospital" means a licensed facility as defined in G.S. 131E-176 or an acute care in-patient diagnostic and treatment facility located within the State of North Carolina that is owned and operated by an agency of the United States government.

(26) "Inclusive Trauma System" means an organized, multi-disciplinary, evidence-based approach to provide quality care and to improve measurable outcomes for all defined injured patients. EMS, hospitals, other health systems, and clinicians shall participate in a structured manner through leadership, advocacy, injury prevention, education, clinical care, performance improvement, and research resulting in integrated trauma care.

(27) "Infectious Disease Control Policy" means a written policy describing how the EMS system will protect and prevent its patients and EMS professionals from exposure and illness associated with contagions and infectious disease.

(28) "Lead RAC Agency" means the agency (comprised of one or more Level I or II trauma centers) that provides staff support and serves as the coordinating entity for trauma planning.

(29) "Level I Trauma Center" means a hospital that has the capability of providing guidance, research, and total care for every aspect of injury from prevention to rehabilitation.

(30) "Level II Trauma Center" means a hospital that provides trauma care regardless of the severity of the injury, but may lack the comprehensive care as a Level I trauma center, and does not have trauma research as a primary objective.

(31) "Level III Trauma Center" means a hospital that provides assessment, resuscitation, emergency operations, and stabilization, and arranges for hospital transfer as needed to a Level I or II trauma center.

(32) "Medical Crew Member" means EMS personnel or other health care professionals who are licensed or registered in North Carolina and are affiliated with a SCTP.

(33) "Medical Director" means the physician responsible for the medical aspects of the management of a practice setting utilizing credentialed EMS personnel or medical crew members, or a Trauma Center.

(34) "Medical Oversight" means the responsibility for the management and accountability of the medical care aspects of a practice setting utilizing credentialed EMS personnel or medical crew members. Medical Oversight includes physician direction of the initial education and continuing education of EMS personnel or medical crew members; development and monitoring of both operational and treatment protocols; evaluation of the medical care rendered by EMS personnel or medical crew members; participation in system or program evaluation; and directing, by two-way voice communications, the medical care rendered by the EMS personnel or medical crew members.

(35) "Mobile Integrated Healthcare" means utilizing credentialed personnel who have received additional training as determined by the Alternative Practice Setting medical director to provide knowledge and skills for the healthcare provider program needs.

(36) "Office of Emergency Medical Services" means a section of the Division of Health Service Regulation of the North Carolina Department of Health and Human Services located at 1201 Umstead Drive, Raleigh, North Carolina 27603.

(37) "On-line Medical Control" means the medical supervision or oversight provided to EMS personnel through direct communication in-person, via radio, cellular phone, or other communication device during the time the patient is under the care of an EMS professional.

(38) "Operational Protocols" means the administrative policies and procedures of an EMS System or that provide guidance for the day-to-day operation of the system.

(39) "Physician" means a medical or osteopathic doctor licensed by the North Carolina Medical Board to practice medicine in the state of North Carolina.

(40) "Regional Advisory Committee" means a committee comprised of a lead RAC agency and a group representing trauma care providers and the community, for the purpose of regional planning, establishing, and maintaining a coordinated trauma system.

(41) "Request for Proposal" means a State document that must be completed by each hospital seeking initial or renewal trauma center designation.

(42) "Specialized Ambulance Protocol Summary (SAPS) means a document listing of all standard medical equipment, supplies, and medications, approved by the Specialty Care or Air Medical Program Medical Director as sufficient to manage the anticipated number and severity of injury or

illness of the patients, for all vehicles used in the program based on the treatment protocols and approved by the OEMS.

(43) "Significant Failure to Comply" means a degree of non-compliance determined by the OEMS during compliance monitoring to exceed the ability of the local EMS System to correct, warranting enforcement action pursuant to Section .1500 of this Subchapter.

(44) "Specialty Care Transport Program" means a program designed and operated for the transportation of a patient by ground or air requiring specialized interventions, monitoring, and staffing by a paramedic who has received additional training as determined by the program Medical Director beyond the minimum training prescribed by the OEMS, or by one or more other healthcare professional(s) qualified for the provision of specialized care based on the patient's condition.

(45) "Specialty Care Transport Program Continuing Education Coordinator" means a Level I EMS Instructor within a SCTP who is responsible for the coordination of EMS continuing education programs for EMS personnel within the program.

(46) "Stretcher" means any wheeled or portable device capable of transporting a person in a recumbent position and may only be used in an ambulance vehicle permitted by the Department.

(47) "Stroke" means an acute cerebrovascular hemorrhage or occlusion resulting in a neurologic deficit.

(48) "System Continuing Education Coordinator" means the Level II EMS Instructor designated by the local EMS System who is responsible for the coordination of EMS continuing education programs.

(49) "System Data" means all information required for daily electronic submission to the OEMS by all EMS Systems using the EMS data set, data dictionary, and file format as specified in "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," incorporated herein by reference including subsequent amendments and editions. This document is available from the OEMS at https://oems.nc.gov/systems at no cost.

(50) "Trauma Center" means a hospital designated by the State of North Carolina and distinguished by its ability to manage, on a 24-hour basis, the severely injured patient or those at risk for severe injury.

(51) "Trauma Patient" means any patient with an ICD-CM discharge diagnosis as defined in the "North Carolina Trauma Registry Data Dictionary," incorporated herein by reference, including subsequent amendments and editions. This document is available from the OEMS online at https://oems.nc.gov/wp-content/uploads/2022/10/datadictionary.pdf at no cost.

(52) "Trauma Program" means an administrative entity that includes the trauma service and coordinates other trauma-related activities. It shall also include the trauma Medical Director, trauma program manager/trauma coordinator, and trauma registrar. This program's reporting structure shall give it the ability to interact with at least equal authority with other departments in the hospital providing patient care.

(53) "Trauma Registry" means a disease-specific data collection composed of a file of uniform data elements that describe the injury event, demographics, pre-hospital information, diagnosis, care, outcomes, and costs of treatment for injured patients collected and electronically submitted as defined by the OEMS. The elements of the Trauma Registry can be accessed online at https://oems.nc.gov/wp-content/uploads/2022/10/datadictionary.pdf at no cost.

(54) "Treatment Protocols" means a document approved by the Medical Directors of the local EMS System, Specialty Care Transport Program, Alternative Practice Setting, or Trauma Center and the OEMS specifying the diagnostic procedures, treatment procedures, medication administration, and patient-care-related policies that shall be completed by EMS personnel or medical crew members based upon the assessment of a patient.

(55) "Triage" means the assessment and categorization of a patient to determine the level of EMS and healthcare facility based care required.

(56) "Water Ambulance" means a watercraft specifically configured and medically equipped to transport patients.

History Note: *Authority G.S. 131E-155(6b); 131E-162; 143-508(b); 143-508(d)(1); 143-508(d)(2); 143-508(d)(3); 143-508(d)(4); 143-508(d)(5); 143-508(d)(6); 143-508(d)(7); 143-508(d)(8); 143-508(d)(13); 143-518(a)(5);*
Temporary Adoption Eff. January 1, 2002;

Eff. April 1, 2003;
Amended Eff. March 3, 2009 pursuant to E.O. 9, Beverly Perdue, March 3, 2009;
Pursuant to G.S. 150B-21.3(c), a bill was not ratified by the General Assembly to disapprove this rule;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021; September 1, 2019; July 1, 2018.

10A NCAC 13P .0103 AIR MEDICAL PROGRAM
10A NCAC 13P .0104 ASSISTANT MEDICAL DIRECTOR
10A NCAC 13P .0105 CONVALESCENT AMBULANCE
10A NCAC 13P .0106 EDUCATIONAL MEDICAL ADVISOR
10A NCAC 13P .0107 EMS EDUCATIONAL INSTITUTION

History Note: Authority G.S. 143-508(b); 143-508(d)(1),(d)(3),(d)(4),(d)(8);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Repealed Eff. January 1, 2009.

10A NCAC 13P .0108 EMS INSTRUCTOR

History Note: Authority G.S. 131E-155(a)(7a); 143-508(b); 143-508(d)(3); 143-508(d)(4);
Temporary Adoption Eff. January 1, 2002;
Repealed Eff. January 1, 2004.

10A NCAC 13P .0109 EMS NONTRANSPORTING VEHICLE
10A NCAC 13P .0110 EMS SYSTEM
10A NCAC 13P .0111 GROUND AMBULANCE
10A NCAC 13P .0112 MEDICAL CREW MEMBERS
10A NCAC 13P .0113 MEDICAL DIRECTOR
10A NCAC 13P .0114 MEDICAL OVERSIGHT
10A NCAC 13P .0115 MODEL EMS SYSTEM
10A NCAC 13P .0116 OFFICE OF EMERGENCY MEDICAL SERVICES
10A NCAC 13P .0117 OPERATIONAL PROTOCOLS
10A NCAC 13P .0118 PHYSICIAN
10A NCAC 13P .0119 EMS PEER REVIEW COMMITTEE
10A NCAC 13P .0120 SPECIALTY CARE TRANSPORT PROGRAM
10A NCAC 13P .0121 SPECIALTY CARE TRANSPORT PROGRAM CONTINUING EDUCATION COORDINATOR
10A NCAC 13P .0122 SYSTEM CONTINUING EDUCATION COORDINATOR
10A NCAC 13P .0123 TREATMENT PROTOCOLS
10A NCAC 13P .0124 WATER AMBULANCE

History Note: Authority G.S. 131E-155(a)(6b); 143-508(b); 143-508(d)(1), (d)(3), (d)(6),(d)(7), (d)(8), (d)(13); 143-518(a)(5);
Temporary Adoption Eff. January 1, 2002;
Eff. January 1, 2004; April 1, 2003;
Amended Eff. January 1, 2004;
Repealed Eff. January 1, 2009.

SECTION .0200 – EMS SYSTEMS

10A NCAC 13P .0201 EMS SYSTEM REQUIREMENTS

(a) County governments shall establish EMS Systems. Each EMS System shall have:

(1) a defined geographical service area for the EMS System. The minimum service area for an EMS System shall be one county. There may be multiple EMS Provider service areas within an EMS

System. The highest level of care offered within any EMS Provider service area shall be available to the citizens within that service area 24 hours a day, seven days a week;

(2) a defined scope of practice for all EMS personnel functioning in the EMS System within the parameters set forth by the North Carolina Medical Board pursuant to G.S. 143-514;

(3) written policies and procedures describing the dispatch, coordination, and oversight of all responders that provide EMS care, specialty patient care skills, and procedures as set forth in Rule .0301 of this Subchapter, and ambulance transport within the system;

(4) at least one licensed EMS Provider;

(5) a listing of permitted ambulances to provide coverage to the service area 24 hours a day, seven days a week;

(6) personnel credentialed to perform within the scope of practice of the system and to staff the ambulance vehicles as required by G.S. 131E-158. There shall be a written plan for the use of credentialed EMS personnel for all practice settings used within the system;

(7) written policies and procedures specific to the utilization of the EMS System's EMS Care data for the daily and on-going management of all EMS System resources;

(8) a written Infectious Disease Control Policy as defined in Rule .0102 of this Subchapter and written procedures that are approved by the EMS System Medical Director that address the cleansing and disinfecting of vehicles and equipment that are used to treat or transport patients;

(9) a listing of resources that will provide online medical direction for all EMS Providers operating within the EMS System;

(10) an EMS communication system that provides for:

(A) public access to emergency services by dialing 9-1-1 within the public dial telephone network as the primary method for the public to request emergency assistance. This number shall be connected to the PSAP with immediate assistance available such that no caller will be instructed to hang up the telephone and dial another telephone number. A person calling for emergency assistance shall not be required to speak with more than two persons to request emergency medical assistance;

(B) a PSAP operated by public safety telecommunicators with training in the management of calls for medical assistance available 24 hours a day, seven days a week;

(C) dispatch of the most appropriate emergency medical response unit or units to any caller's request for assistance. The dispatch of all response vehicles shall be in accordance with a written EMS System plan for the management and deployment of response vehicles including requests for mutual aid; and

(D) two-way radio voice communications from within the defined service area to the PSAP and to facilities where patients are transported. The PSAP shall maintain all required FCC radio licenses or authorizations;

(11) written policies and procedures for addressing the use of SCTP and Air Medical Programs resources utilized within the system;

(12) a written continuing education program for all credentialed EMS personnel, under the direction of a System Continuing Education Coordinator, developed and modified based on feedback from EMS Care system data, review, and evaluation of patient outcomes and quality management peer reviews, that follows the criteria set forth in Rule .0501 of this Subchapter;

(13) written policies and procedures to address management of the EMS System that includes:

(A) triage and transport of all acutely ill and injured patients with time-dependent or other specialized care issues including trauma, stroke, STEMI, burn, and pediatric patients that may require the bypass of other licensed health care facilities and that are based upon the expanded clinical capabilities of the selected healthcare facilities;

(B) triage and transport of patients to facilities outside of the system;

(C) arrangements for transporting patients to identified facilities when diversion or bypass plans are activated;

(D) reporting, monitoring, and establishing standards for system response times using system data;

(E) a disaster plan;

(F) a mass-gathering plan that includes how the provision of EMS standby coverage for the public-at-large will be provided;

(G) a mass-casualty plan;

(H) a weapons plan for any weapon as set forth in Rule .0216 of this Section;
(I) a plan on how EMS personnel shall report suspected child abuse pursuant to G.S. 7B-301;
(J) a plan on how EMS personnel shall report suspected abuse of the disabled pursuant to G.S. 108A-102;
(K) a plan on how each responding agency is to maintain a current roster of its personnel providing EMS care within the county under the provider number issued pursuant to Paragraph (c) of this Rule, in the OEMS credentialing and information database; and
(L) a plan on how each licensed hospital facility will use and maintain two-way radio communication for receiving in coming patient from EMS providers;
(14) affiliation as defined in Rule .0102 of this Subchapter with a trauma RAC as required by Rule .1101(b) of this Subchapter; and
(15) medical oversight as required by Section .0400 of this Subchapter.

(b) Each EMS System that utilizes emergency medical dispatching agencies applying the principles of EMD or offering EMD services, procedures, or programs to the public shall have:
(1) a defined service area for each agency;
(2) appropriate personnel within each agency, credentialed in accordance with the requirements set forth in Section .0500 of this Subchapter, to ensure EMD services to the citizens within that service area are available 24 hours per day, seven days a week, and a written policy describing how the agency will maintain a roster of credentialed EMD personnel in the OEMS credentialing and information database; and
(3) EMD responsibilities in special situations, such as disasters, mass-casualty incidents, or situations requiring referral to specialty hotlines; and
(4) EMD medical oversight as required in Section .0400 of this Subchapter.

(c) The EMS System shall obtain provider numbers from the OEMS for each entity that provides EMS Care within the county.

(d) An application to establish an EMS System shall be submitted by the county to the OEMS for review. When the system is comprised of more than one county, only one application shall be submitted. The proposal shall demonstrate that the system meets the requirements in Paragraph (a) of this Rule. System approval shall be granted for a period of six years. Systems shall apply to OEMS for reapproval no more than 90 days prior to expiration.

History Note: Authority G.S. 131E-155(1); 131E-155(6); 131E-155(7); 131E-155(8); 131E-155(9); 131E-155(13a); 131E-155(15); 143-508(b); 143-508(d)(1); 143-508(d)(2); 143-508(d)(3); 143-508(d)(5); 143-508(d)(8); 143-508(d)(9); 143-508(d)(10); 143-508(d)(13); 143-517; 143-518;
Temporary Adoption Eff. January 1, 2002;
Eff. August 1, 2004;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2018.

10A NCAC 13P .0202 MODEL EMS SYSTEMS

History Note: Authority G.S. 143-508(b); 143-508(d)(1), (d)(3), (d)(5), (d)(8), (d)(9), (d)(10),(d)(13); 143-509(1), (3), (4), (5);
Temporary Adoption Eff. January 1, 2002;
Eff. January 1, 2004;
Repealed Eff. March 1, 2009.

10A NCAC 13P .0203 SPECIAL SITUATIONS

(a) Upon written request from an EMS system or systems, tribal government, or federal jurisdiction having recognized province in North Carolina, the North Carolina Medical Care Commission may approve the furnishing and providing of services within the scope of practice of EMD, EMR, EMT, AEMT, or Paramedic in North Carolina.

(b) This approval shall be granted where the North Carolina Medical Care Commission concludes there exists an inability to address the criteria for EMS System development as set forth in Rule .0201 of this Section and the

deficiency cannot be rectified due to insufficient resources or because of a lack of geographical access within the respective EMS system or systems.

History Note: Authority G.S. 143-508(b);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2004;
Readopted Eff. April 1, 2017.

10A NCAC 13P .0204 EMS PROVIDER LICENSE REQUIREMENTS

(a) Any firm, corporation, agency, organization, or association that provides non-transportation emergency medical services at the AEMT or Paramedic level shall be licensed by the Department as an EMS Provider by meeting and maintaining the criteria defined in Paragraph (b) of this Rule.

(b) Any firm, corporation, agency, organization, or association that provides emergency medical transportation services shall be licensed as an EMS Provider by meeting and maintaining the following criteria:

(1) be affiliated as defined in Rule .0102(3) of this Subchapter with each EMS System where there is to be a physical base of operation or where the EMS Provider will provide point-to-point patient transport within the system;

(2) present an application for a permit for any ambulance and EMS non-transporting vehicle that will be in service as required by G.S. 131E-156, and meet the requirements of Rules .0207 and .0213 of this Section;

(3) submit a written plan detailing how the EMS Provider will furnish credentialed personnel pursuant to G.S. 131E-158;

(4) where there are franchise ordinances pursuant to G.S. 153A-250 in effect that cover the proposed service areas of each EMS system of operation, provide written documentation reflecting a current franchise to operate, or of impending receipt of a franchise, from each county. In counties where there is no franchise ordinance in effect, present a signature from each EMS System representative authorizing the EMS Provider to affiliate as required by Subparagraph (b)(1) of this Rule;

(5) provide inspection, repair, cleaning, and maintenance of all EMS responding ground vehicles and maintain records for a period of time determined by the EMS System, and make available for inspection by the OEMS verifying compliance with this Subparagraph;

(6) collect and within 24 hours electronically submit to the OEMS EMS Care data that uses the EMS data set and data dictionary as specified in "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection;"

(7) develop and implement written operational protocols for the management of equipment, supplies, and medications and maintain records for a period of time determined by the EMS System, and make available for inspection by the OEMS verifying compliance with this Subparagraph. These protocols shall include a methodology:

(A) to assure that each vehicle contains the required equipment and supplies on each response;

(B) for cleaning and maintaining the equipment and vehicles; and

(C) to assure that supplies and medications are not used beyond the expiration date and stored in a temperature controlled atmosphere according to manufacturer's specifications.

(c) An EMS Provider may renew its license by presenting documentation to the OEMS that the Provider meets the criteria set forth in Paragraph (b) of this Rule.

(d) Air Medical Programs are exempt from the requirements set forth in Subparagraphs (b)(1) and (b)(4) of this Rule.

History Note: Authority G.S. 131E-155.1(c); 143-508(d)(1); 143-508(d)(5); 143-508(d)(13);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2004;
Amended Eff. March 3, 2009 pursuant to E.O. 9, Beverly Perdue, March 3, 2009;
Pursuant to G.S. 150B-21(c), a bill was not ratified by the General Assembly to disapprove this rule;
Readopted Eff. June 1, 2018.

10A NCAC 13P .0205 EMS PROVIDER LICENSE CONDITIONS

(a) Applications for an EMS Provider License must be received by the OEMS at least 30 days prior to the date that the EMS Provider proposes to initiate service. Applications for renewal of an EMS Provider License must be received by the OEMS at least 30 days prior to the expiration date of the current license.

(b) Only one license shall be issued to each EMS Provider. The Department shall issue a license to the EMS Provider following verification of compliance with applicable laws and rules.

(c) EMS Provider Licenses shall not be transferred.

(d) The license shall be posted in a prominent location accessible to public view at the primary business location of the EMS Provider.

(e) EMS Provider Licenses may not be issued by the Department to any firm, corporation, agency, organization or association that does not intend to provide emergency medical services as part of its operation to the citizens of North Carolina.

History Note: Authority G.S. 131E-155.1(c);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. February 1, 2009; January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

10A NCAC 13P .0206 TERM OF EMS PROVIDER LICENSE

(a) EMS Provider Licenses remain in effect for six years unless any of the following occurs:

- (1) the Department imposes an administrative sanction which specifies license expiration;
- (2) the EMS Provider closes or goes out of business;
- (3) the EMS Provider changes name or ownership; or
- (4) failure to continue to comply with Rule .0204 of this Section.

(b) When the name or ownership of the EMS Provider changes, an EMS Provider License application shall be submitted to the OEMS at least 30 days prior to the effective date of the change.

History Note: Authority G.S. 131E-155.1(c);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

10A NCAC 13P .0207 GROUND AMBULANCE: VEHICLE AND EQUIPMENT REQUIREMENTS

(a) To be permitted as a Ground Ambulance, a vehicle shall have:

- (1) a patient compartment that meets the following interior dimensions:
  - (A) the length, measured on the floor from the back of the driver's compartment, driver's seat or partition to the inside edge of the rear loading doors, is at least 102 inches; and
  - (B) the height is at least 48 inches over the patient area, measured from the approximate center of the floor, exclusive of cabinets or equipment;
- (2) patient care equipment and supplies as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection." The equipment and supplies shall be clean, in working order, and secured in the vehicle;
- (3) other equipment that includes:
  - (A) one fire extinguisher mounted in a quick release bracket that is either a dry chemical or all-purpose type and has a pressure gauge; and
  - (B) the availability of one pediatric restraint device to safely transport pediatric patients and children under 40 pounds in the patient compartment of the ambulance;
- (4) the name of the EMS Provider permanently displayed on each side of the vehicle;
- (5) reflective tape affixed to the vehicle such that there is reflectivity on all sides of the vehicle;
- (6) emergency warning lights and audible warning devices mounted on the vehicle as required by G.S. 20-125. All warning devices shall function properly;

(7) no structural or functional defects that may adversely affect the patient, the EMS personnel, or the safe operation of the vehicle;
(8) an operational two-way radio that:
(A) is mounted to the ambulance and installed for safe operation and controlled by the ambulance driver;
(B) has the range, radio frequencies, and capabilities to establish and maintain two-way voice radio communication from within the defined service area of the EMS System to the emergency communications center or PSAP designated to direct or dispatch the deployment of the ambulance;
(C) is capable of establishing two-way voice radio communication from within the defined service area to the emergency department of the hospital(s) where patients are routinely transported and to facilities that provide on-line medical direction to EMS personnel;
(D) is equipped with a radio control device in the patient compartment capable of operation by the patient attendant to receive on-line medical direction; and
(E) is licensed or authorized by the FCC;
(9) permanently installed heating and air conditioning systems; and
(10) a copy of the EMS System patient care treatment protocols.

(b) Ground ambulances permitted by the OEMS that do not back up the 911 EMS System shall be exempt from requirements for two-way radio communications as defined in Subparagraph (a)(8) of this Rule. A two-way radio or radiotelephone device such as a cellular telephone shall be available to summon emergency assistance.

(c) Communication instruments or devices such as data radio, facsimile, computer, or telemetry radio shall be in addition to the mission dedicated dispatch radio and shall function independently from the mission dedicated radio.

History Note: *Authority G.S. 131E-157(a); 143-508(d)(8);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. April 1, 2024.

10A NCAC 13P .0208 CONVALESCENT AMBULANCE: VEHICLE AND EQUIPMENT REQUIREMENTS

(a) To be permitted as a Convalescent Ambulance, a vehicle shall have:
(1) a patient compartment that meets the following interior dimensions:
(A) the length, measured on the floor from the back of the driver's compartment, driver's seat or partition to the inside edge of the rear loading doors, is at least 102 inches; and
(B) the height is at least 48 inches over the patient area, measured from the approximate center of the floor, exclusive of cabinets or equipment;
(2) patient care equipment and supplies as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost. The equipment and supplies shall be clean, in working order, and secured in the vehicle;
(3) other equipment including:
(A) one fire extinguisher mounted in a quick release bracket that is either a dry chemical or all-purpose type and has a pressure gauge; and
(B) the availability of one pediatric restraint device to safely transport pediatric patients and children under 40 pounds in the patient compartment of the ambulance;
(4) permanently installed heating and air conditioning systems; and
(5) a copy of the EMS System patient care treatment protocols.

(b) Convalescent Ambulances shall:
(1) not be equipped, permanently or temporarily, with any emergency warning devices, audible or visual, other than those required by Federal Motor Vehicle Safety Standards;
(2) have the name of the EMS Provider permanently displayed on each side of the vehicle;

(3) not have emergency medical symbols, such as the Star of Life, block design cross, or any other medical markings, symbols, or emblems, including the word "EMERGENCY," on the vehicle;
(4) have the words "CONVALESCENT AMBULANCE" lettered on both sides and on the rear of the vehicle body; and
(5) have reflective tape affixed to the vehicle such that there is reflectivity on all sides of the vehicle.

(c) A two-way radio or radiotelephone device such as a cellular telephone shall be available to summon emergency assistance for a vehicle permitted as a convalescent ambulance.
(d) The convalescent ambulance shall not have structural or functional defects that may adversely affect the patient, the EMS personnel, or the safe operation of the vehicle.

History Note: Authority G.S. 131E-157(a); 143-508(d)(8);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

10A NCAC 13P .0209 AIR MEDICAL AMBULANCE: VEHICLE AND EQUIPMENT REQUIREMENTS

To be permitted as an Air Medical Ambulance, an aircraft shall meet the following requirements:
(1) configuration of the aircraft patient care compartment does not compromise the ability to provide care or prevent performing in-flight emergency patient care procedures as approved by the program Medical Director;
(2) the aircraft has on-board patient care equipment and supplies as defined in the treatment protocols for the program written by the Medical Director and approved by the OEMS. The equipment and supplies shall be clean, in working order, and secured in the aircraft;
(3) there is installed in the rotary-wing aircraft an internal voice communication system to allow for communication between the medical and flight crew;
(4) the program Medical Director designates the combination of medical equipment specified in Item (2) of this Rule that is carried on a mission based on anticipated patient care needs;
(5) the name of the EMS Provider is permanently displayed on each side of the aircraft;
(6) the rotary-wing aircraft is equipped with a two-way voice radio licensed by the FCC capable of operation on any frequency required to allow communications with public safety agencies such as fire departments, police departments, ambulance and rescue units, hospitals, and local government agencies, within the service area;
(7) in addition to equipment required by applicable air worthiness certificates and Federal Aviation Regulations 14 CFR Part 91 and Part 135 which are herein incorporated by reference, including all subsequent amendments and editions, any rotary-wing aircraft permitted shall have the following functioning equipment to help ensure the safety of patients, crew members, and ground personnel, patient comfort, and medical care:
    (a) Global Positioning System;
    (b) an external search light that can be operated from inside the aircraft;
    (c) survival gear appropriate for the service area and the number, age, and type of patients; and
    (d) permanently installed environmental control unit (ECU) capable of both heating and cooling the patient compartment of the aircraft;
(8) the availability of one pediatric restraint device to safely transport pediatric patients and children under 40 pounds in the patient compartment of the air medical ambulance;
(9) the aircraft has no structural or functional defects that may adversely affect the patient, or the EMS personnel; and
(10) a copy of the patient care treatment protocols set forth in Rules .0405 and .0406 of this Subchapter, either paper or electronic, carried aboard the aircraft.

History Note: Authority G.S. 131E-157(a); 143-508(d)(8);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;

Amended Eff. January 1, 2004;
Amended Eff. March 3, 2009 pursuant to E.O. 9, Beverly Perdue, March 3, 2009;
Pursuant to G.S. 150B-21.3(c), a bill was not ratified by the General Assembly to disapprove this rule;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. January 1, 2017.

10A NCAC 13P .0210 WATER AMBULANCE: WATERCRAFT AND EQUIPMENT REQUIREMENTS

To be permitted as a Water Ambulance, a watercraft shall meet the following requirements:

(1) The watercraft shall have a patient care area that:
  (a) provides access to the head, torso, and lower extremities of the patient while providing sufficient working space to render patient care;
  (b) is covered to protect the patient and EMS personnel from the elements; and
  (c) has an opening of sufficient size to permit the safe loading and unloading of a person occupying a litter.

(2) The watercraft shall have on board patient care equipment and supplies as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost. The equipment and supplies shall be clean, in working order, and secured in the vehicle.

(3) Water ambulances shall have the name of the EMS Provider permanently displayed on each side of the watercraft.

(4) Water ambulances shall have a 360-degree beacon warning light in addition to warning devices required in Chapter 75A, Article 1, of the North Carolina General Statutes.

(5) Water ambulances shall be equipped with:
  (a) two floatable rigid long backboards with proper accessories for securing infant, pediatric, and adult patients and stabilization of the head and neck;
  (b) one floatable litter with patient restraining straps and capable of being secured to the watercraft;
  (c) one fire extinguisher mounted in a quick release bracket that is either a dry chemical or all-purpose type and has a pressure gauge;
  (d) lighted compass;
  (e) radio navigational aids such as ADF (automatic directional finder), Satellite Global Navigational System, navigational radar, or other comparable radio equipment suited for water navigation;
  (f) marine radio; and
  (g) the availability of one pediatric restraint device to safely transport pediatric patients under 40 pounds in the patient compartment of the ambulance;

(6) The water ambulance shall not have structural or functional defects that may adversely affect the patient, the EMS personnel, or the safe operation of the watercraft.

(7) Water ambulances shall have a copy of the EMS System patient care treatment protocols.

History Note: *Authority G.S. 131E-157(a); 143-508(d)(8);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

10A NCAC 13P .0211 AMBULANCE PERMIT CONDITIONS

(a) An EMS provider shall apply to the OEMS for the appropriate Ambulance Permit prior to placing an ambulance in service.

(b) The Department shall issue a permit for an ambulance following verification of compliance with applicable laws and rules.

(c) Only one Ambulance Permit shall be issued for each ambulance.
(d) An ambulance shall be permitted in only one category.
(e) Ambulance Permits shall not be transferred except in the case of Air Medical Ambulance replacement aircraft when the primary aircraft is out of service.
(f) The Ambulance Permit shall be posted as designated by the OEMS inspector.

History Note: Authority G.S. 131E-157(a); 143-508(d)(8);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

10A NCAC 13P .0212 TERM OF AMBULANCE PERMIT

Ambulance Permits remain in effect for two years unless any of the following occurs:

(1) The Department imposes an administrative sanction which specifies permit expiration;
(2) The EMS Provider closes or goes out of business;
(3) The EMS Provider changes name or ownership; or
(4) Failure to comply with the applicable Paragraphs of Rules .0207, .0208, .0209, or .0210 of this Section.

History Note: Authority G.S. 131E-157(a); 143-508(d)(8);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

10A NCAC 13P .0213 EMS NONTRANSPORTING VEHICLE REQUIREMENTS

(a) To be permitted as an EMS Nontransporting Vehicle, a vehicle shall:

(1) have patient care equipment and supplies as defined in the treatment protocols for the system. The equipment and supplies shall be clean, in working order, and secured in the vehicle.
(2) have the name of the EMS Provider permanently displayed on each side of the vehicle.
(3) have reflective tape affixed to the vehicle such that there is reflectivity on all sides of the vehicle.
(4) have emergency warning lights and audible warning devices mounted on the vehicle as required by G.S. 20-125 in addition to those required by Federal Motor Vehicle Safety Standards. All warning devices shall function properly.
(5) not have structural or functional defects that may adversely affect the EMS personnel or the safe operation of the vehicle.
(6) have one fire extinguisher that is a dry chemical or all-purpose type with a pressure gauge, mounted in a quick-release bracket.
(7) have an operational two-way radio that:
    (A) is mounted to the EMS Nontransporting Vehicle and installed for safe operation and controlled by the driver;
    (B) has sufficient range, radio frequencies, and capabilities to establish and maintain two-way voice radio communication from within the defined service area of the EMS System to the emergency communications center or PSAP designated to direct or dispatch the deployment of the ambulance;
    (C) is capable of establishing two-way voice radio communication from within the defined service area to facilities that provide on-line medical direction to EMS personnel; and
    (D) is licensed or authorized by the FCC.
(8) not use a radiotelephone device such as a cellular telephone as the only source of two-way radio voice communication.
(9) have a copy of the local EMS System patient care treatment protocols.

(b) Communication instruments or devices such as data radio, facsimile, computer, or telemetry radio shall be in addition to the mission dedicated dispatch radio and shall function independently from the mission-dedicated radio.

History Note: Authority G.S. 143-508(d)(8);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

10A NCAC 13P .0214 EMS NON-TRANSPORTING VEHICLE PERMIT CONDITIONS

(a) A licensed EMS provider shall apply to the OEMS for an EMS non-transporting Vehicle Permit prior to placing such vehicle in service.
(b) The OEMS shall issue a permit for a vehicle following verification of compliance with applicable laws and rules.
(c) Only one EMS Non-transporting Vehicle Permit shall be issued for each vehicle.
(d) EMS Non-transporting Vehicle Permits shall not be transferred.
(e) The EMS Non-transporting Vehicle Permit shall be posted on the vehicle by the OEMS inspector.
(f) Vehicles that are not owned or leased by the licensed EMS Provider are ineligible for permitting.

History Note: Authority G.S. 143-508(d)(8);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. January 1, 2017.

10A NCAC 13P .0215 TERM OF EMS NONTRANSPORTING VEHICLE PERMIT

EMS Nontransporting Vehicle Permits remain in effect for two years, unless any of the following occurs:
(1) The Department imposes an administrative sanction that specifies permit expiration;
(2) The EMS Provider closes or goes out of business;
(3) The EMS Provider changes name or ownership; or
(4) Failure to comply with Rule .0213 of this Section.

History Note: Authority G.S. 143-508(d)(8);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

10A NCAC 13P .0216 WEAPONS AND EXPLOSIVES FORBIDDEN

(a) Weapons, whether lethal or non-lethal, and explosives shall not be worn or carried aboard an ambulance or EMS non-transporting vehicle within the State of North Carolina when the vehicle is operating in any patient treatment or transport capacity or is available for such function.
(b) Conducted electrical weapons and chemical irritants such as mace, pepper (oleoresin capsicum) spray, and tear gas shall be considered weapons for the purpose of this Rule.
(c) This Rule shall apply whether such weapons and explosives are concealed or visible.
(d) If any weapon is found to be in the possession of a patient or person accompanying the patient during transportation, the weapon shall be safely secured in accordance with the weapons policy as set forth in Rule .0201 of this Section.
(e) Weapons authorized for use by EMS personnel attached to a law enforcement tactical team in accordance with the weapons policy as set forth in Rule .0201 of this Section may be secured in a locked, dedicated compartment or gun safe mounted within the ambulance or non-transporting vehicle for use when dispatched in support of the law enforcement tactical team, but are not to be worn or carried open or concealed by any EMS personnel in the performance of normal EMS duties under any circumstances.
(f) This Rule shall not apply to duly appointed law enforcement officers.

(g) Safety flares are authorized for use on an ambulance with the following restrictions:
(1) these devices are not stored inside the patient compartment of the ambulance; and
(2) these devices shall be packaged and stored to prevent accidental discharge or ignition.

History Note: Authority G.S. 131E-157(a); 143-508(d)(8);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024.

10A NCAC 13P .0217 MEDICAL AMBULANCE/EVACUATION BUS: VEHICLE AND EQUIPMENT REQUIREMENTS

(a) A Medical Ambulance/Evacuation bus is a multiple passenger vehicle configured and medically equipped for emergency and non-emergency transport of at least three stretcher bound patients with traumatic or medical conditions.
(b) To be permitted as a Medical Ambulance/Evacuation Bus, a vehicle shall have:
(1) a non-light penetrating sliding curtain installed behind the driver from floor-to-ceiling and from side-to-side to keep all light from the patient compartment from reaching the driver's area during vehicle operation at night;
(2) patient care equipment and supplies as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection." The equipment and supplies shall be clean, in working order, and secured in the vehicle;
(3) five-pound fire extinguishers mounted in a quick release bracket located inside the patient compartment at the front and rear of the vehicle that are either a dry chemical or all-purpose type and have pressure gauges;
(4) monitor alarms installed inside the patient compartment at the front and rear of the vehicle to warn of unsafe buildup of carbon monoxide;
(5) the name of the EMS provider permanently displayed on each side of the vehicle;
(6) reflective tape affixed to the vehicle such that there is reflectivity on all sides of the vehicle;
(7) emergency warning lights and audible warning devices mounted on the vehicle as required by G.S. 20-125. All warning devices shall function properly;
(8) no structural or functional defects that may adversely affect the patient, the EMS personnel, or the safe operation of the vehicle;
(9) an operational two-way radio that:
(A) is mounted to the ambulance and installed for safe operation and controlled by the ambulance driver;
(B) has the range, radio frequencies, and capabilities to establish and maintain two-way voice radio communication from within the defined service area of the EMS System to the emergency communications center or PSAP designated to direct or dispatch the deployment of the ambulance;
(C) is capable of establishing two-way voice radio communication from within the defined service area to the emergency department of the hospital(s) where patients are routinely transported and to facilities that provide on-line medical direction to EMS personnel;
(D) is equipped with a radio control device in the patient compartment capable of operation by the patient attendant to receive on-line medical direction; and
(E) is licensed or authorized by the FCC;
(10) permanently installed heating and air conditioning systems; and
(11) a copy of the EMS System patient care treatment protocols.
(c) A Medical Ambulance/Evacuation Bus shall not use a radiotelephone device such as a cellular telephone as the only source of two-way radio voice communication.
(d) Communication instruments or devices such as data radio, facsimile, computer, or telemetry radio shall be in addition to the mission dedicated dispatch radio and shall function independently from the mission dedicated radio.
(e) The EMS System medical director shall designate the combination of medical equipment as required in Subparagraph (b)(2) of this Rule that is carried on a mission based on anticipated patient care needs.
(f) The ambulance permit for this vehicle shall remain in effect for two years unless any of the following occurs:
(1) the Department imposes an administrative sanction which specifies permit expiration;

(2) the EMS Provider closes or goes out of business;
(3) the EMS Provider changes name or ownership; or
(4) failure to comply with the applicable Paragraphs of this Rule.

History Note: Authority G.S. 131E-157(a); 143-508(d)(8);
Eff. July 1, 2011;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. April 1, 2024.

10A NCAC 13P .0218 PEDIATRIC SPECIALTY CARE GROUND AMBULANCE: VEHICLE AND EQUIPMENT REQUIREMENTS

(a) A Pediatric Specialty Care Ground Ambulance is an ambulance used to transport only those patients 18 years old or younger with traumatic or medical conditions or for whom the need for specialty care or emergency or non-emergency medical care is anticipated during an inter-facility or discharged patient transport.
(b) To be permitted as a Pediatric Specialty Care Ground Ambulance, a vehicle shall have:
(1) a patient compartment that meets the following interior dimensions:
(A) the length, measured on the floor from the back of the driver's compartment, driver's seat or partition to the inside edge of the rear loading doors, is at least 102 inches; and
(B) the height is at least 48 inches over the patient area, measured from the center of the floor, exclusive of cabinets or equipment;
(2) patient care equipment and supplies as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection." The equipment and supplies shall be clean, in working order, and secured in the vehicle;
(3) one fire extinguisher mounted in a quick release bracket that is either a dry chemical or all-purpose type and has a pressure gauge;
(4) the name of the EMS Provider permanently displayed on each side of the vehicle;
(5) reflective tape affixed to the vehicle such that there is reflectivity on all sides of the vehicle;
(6) emergency warning lights and audible warning devices mounted on the vehicle as required by G.S. 20-125. All warning devices shall function properly;
(7) no structural or functional defects that may adversely affect the patient, the EMS personnel, or the safe operation of the vehicle;
(8) an operational two-way radio that:
(A) is mounted to the ambulance and installed for safe operation and controlled by the ambulance driver;
(B) has the range, radio frequencies, and capabilities to establish and maintain two-way voice radio communication from within the defined service area of the EMS System to the emergency communications center or PSAP designated to direct or dispatch the deployment of the ambulance;
(C) is capable of establishing two-way voice radio communication from within the defined service area to the emergency department of the hospital(s) where patients are routinely transported and to facilities that provide on-line medical direction to EMS personnel;
(D) is equipped with a radio control device in the patient compartment capable of operation by the patient attendant to receive on-line medical direction; and
(E) is licensed or authorized by the FCC;
(9) permanently installed heating and air conditioning systems; and
(10) a copy of the EMS System patient care treatment protocols.
(c) Pediatric Specialty Care Ground ambulances shall not use a radiotelephone device such as a cellular telephone as the only source of two-way radio voice communication.
(d) Communication instruments or devices such as data radio, facsimile, computer, or telemetry radio shall be in addition to the mission dedicated dispatch radio and shall function independently from the mission dedicated radio.
(e) The Specialty Care Transport Program medical director shall designate the combination of medical equipment as required in Subparagraph (b)(2) of this Rule that is carried on a mission based on anticipated patient care needs.
(f) The ambulance permit for this vehicle shall remain in effect for two years unless any of the following occurs:
(1) the Department imposes an administrative sanction which specifies permit expiration;
(2) the EMS Provider closes or goes out of business;

(3) the EMS Provider changes name or ownership; or
(4) failure to comply with the applicable paragraphs of this Rule.

History Note: Authority G.S. 131E-157(a); 143-508(d)(8);
Eff. July 1, 2011;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. April 1, 2024.

10A NCAC 13P .0219 STAFFING FOR MEDICAL AMBULANCE/EVACUATION BUS VEHICLES

Medical Ambulance/Evacuation Bus Vehicles are exempt from the requirements of G.S. 131E-158(a). The EMS System Medical Director, as set forth in Rule .0403(8) of this Subchapter, shall determine the combination and number of EMT, AEMT, or Paramedic personnel that are sufficient to manage the anticipated number and severity of injury or illness of the patients transported in the Medical Ambulance/Evacuation Bus Vehicle.

History Note: Authority G.S. 131E-158(b);
Eff. July 1, 2011;
Readopted Eff. January 1, 2017.

10A NCAC 13P .0220 STAFFING FOR PEDIATRIC SPECIALTY CARE GROUND AMBULANCES

Pediatric Specialty Care Ground Ambulances operated within the approved Specialty Care Transport Program dedicated for inter-facility transport of non-emergent, emergent, and critically ill or injured or discharged Neonatal and Pediatric patients are exempt from the requirements of G.S. 131E-158(a). The Specialty Care Program Medical Director shall determine the staffing that is sufficient to manage the severity of illness or injury of the patients transported in the Pediatric Specialty Care Ground Ambulance.

History Note: Authority G.S. 131E-158(b);
Eff. July 1, 2011;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

10A NCAC 13P .0221 PATIENT TRANSPORTATION BETWEEN HOSPITALS

(a) For the purpose of this Rule, hospital means those facilities as defined in Rule .0102 of this Subchapter.
(b) Every ground ambulance when transporting a patient between hospitals shall be occupied by all of the following:
(1) one person who holds a credential issued by the OEMS as an emergency medical responder or higher who is responsible for the operation of the vehicle and rendering assistance to the patient caregiver when needed; and
(2) at least one of the following individuals as determined by the transferring physician to manage the anticipated severity of injury or illness of the patient who is responsible for the medical aspects of the mission:
(A) emergency medical technician;
(B) advanced EMT;
(C) paramedic;
(D) nurse practitioner;
(E) physician;
(F) physician assistant;
(G) registered nurse; or
(H) respiratory therapist.
(c) Information shall be provided to the OEMS by the licensed EMS provider in the application:
(1) describing the intended staffing pursuant to Rule .0204 of this Section; and
(2) showing authorization pursuant to Rule .0204 of this Section by the county where the EMS provider license is issued to use the staffing in Paragraph (b) of this Rule.
(d) Ambulances used for patient transports between hospitals shall contain all medical equipment, supplies, and medications approved by the Medical Director, based upon the NCCEP treatment protocol guidelines. These

protocol guidelines set forth in Rules .0405 and .0406 of this Subchapter are available online at no cost at https://oems.nc.gov.

History Note: Authority G.S. 131E-155.1; 131E-158(b); 143-508(d)(1); 143-508(d)(8);
Eff. July 1, 2012;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; September 1, 2019.

10A NCAC 13P .0222 TRANSPORT OF STRETCHER BOUND PATIENTS

(a) Any person transported on a stretcher as defined in Rule .0102 of this Subchapter meets the definition of patient as defined in G.S. 131E-155(16).

(b) Stretchers may only be utilized for patient transport in an ambulance permitted by the OEMS in accordance with G.S. 131E-156 and Rule .0211 of this Section.

(c) The Medical Care Commission exempts wheeled chair devices used solely for the transportation of mobility impaired persons seated in an upright position in non-permitted vehicles from the definition of stretcher.

History Note: Authority G.S. 131E-156; 131E-157; 143-508(d)(8);
Eff. January 1, 2017;
Amended Eff. July 1, 2021; July 1, 2018.

10A NCAC 13P .0223 REQUIRED DISCLOSURE AND REPORTING INFORMATION

(a) Applicants for initial and renewal EMS Provider licensing shall disclose the following background information:

(1) any prior name(s) used for providing emergency medical services in North Carolina or any other state;

(2) any felony criminal charges and convictions, under Federal or State law, and any civil actions taken against the applicant or any of its owners or officers in North Carolina or any other state;

(3) any misdemeanor or felony conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;

(4) any misdemeanor or felony conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of EMS care or service;

(5) any current or prior investigations, including outcomes, for alleged Medicare, Medicaid, or other insurance fraud, tax evasion, and fraud;

(6) any revocation or suspension of accreditation; and

(7) any revocation or suspension by any State licensing authority of a license to provide EMS.

(b) Within 30 days of occurrence, a licensed EMS provider shall disclose any changes in the information set forth in Paragraph (a) of this Rule that was provided to the OEMS in its most recent application.

History Note: Authority G.S. 131E-155.1(c); 131E-159; 143-508(d)(1); 143-508(d)(5);
Eff. January 1, 2017.

10A NCAC 13P .0224 GROUND AMBULANCE VEHICLE MANUFACTURING STANDARDS

(a) In addition to the terms defined in Rule .0102 of this Subchapter, the following definitions apply to this Rule:

(1) "Remounted" means a ground ambulance patient compartment module that has been removed from its original chassis and mounted onto a different chassis.

(2) "Refurbished" means upgrading or repairing an existing ground ambulance patient care module or chassis that may not involve replacement of the chassis.

(b) "Ground ambulances" as defined in Rule .0102 of this Subchapter manufactured after July 1, 2018, or remounted after July 1, 2025, that are based and operated in North Carolina shall meet one of the following manufacturing standards:

(1) the Commission on Accreditation of Ambulance Services (CAAS) "Ground Vehicle Standard for Ambulances, which is incorporated herein by reference including all subsequent amendments and editions. This document is available online at no cost at www.groundvehiclestandard.org; or

(2) the National Fire Protection Association (NFPA) 1917-2016 "Standard for Automotive Ambulances," which is incorporated herein by reference including all subsequent amendments and

editions. This document is available for purchase online at www.nfpa.org for a cost of seventy-eight dollars ($78.00).

(c) The following shall be exempt from the criteria set forth in Paragraph (b) of this Rule:

(1) ambulances owned and operated by an agency of the United States government;
(2) ambulances manufactured prior to July 1, 2018;
(3) ambulances remounted prior to July 1, 2025;
(4) "convalescent ambulances" as defined in Rule .0102 of this Subchapter;
(5) refurbished ambulances; or
(6) Medical Ambulance/Evacuation/Bus as set forth in Rule .0217 of this Section.

(d) Effective July 1, 2018, the National Highway Traffic Safety Administration (NHTSA) KKK-A-1822F-Ambulance Manufacturing Standard shall no longer meet the manufacturing standards for new ground ambulances as set forth in Paragraph (b) of the Rule.

(e) Ground ambulances that do not meet the criteria set forth in this Rule shall be ineligible for permitting as set forth in Rule .0211 of this Section.

History Note: *Authority G.S. 131E-156; 131E-157; 143-508(d)(8);*
Eff. January 1, 2018;
Amended Eff. April 1, 2024.

SECTION .0300 – SPECIALTY CARE TRANSPORT PROGRAMS

10A NCAC 13P .0301 SPECIALTY CARE TRANSPORT PROGRAM CRITERIA

(a) EMS Providers seeking designation to provide specialty care transports shall submit an application for program approval to the OEMS at least 60 days prior to field implementation. The application shall document that the program has:

(1) a defined service area that identifies the specific transferring and receiving facilities the program is intended to service;
(2) written policies and procedures implemented for medical oversight meeting the requirements of Section .0400 of this Subchapter;
(3) service available on a 24 hour a day, seven days a week basis;
(4) the capability to provide the patient care skills and procedures as specified in "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection;"
(5) a written continuing education program for EMS personnel, under the direction of the Specialty Care Transport Program Continuing Education Coordinator, developed and modified based upon feedback from program data, review and evaluation of patient outcomes, and quality management review that follows the criteria set forth in Rule .0501 of this Subchapter;
(6) a communication system that provides two-way voice communications for transmission of patient information to medical crew members anywhere in the service area of the program. The SCTP Medical Director shall verify that the communications system is satisfactory for on-line medical direction;
(7) medical crew members that have completed training conducted every six months regarding:
    (A) operation of the EMS communications system used in the program; and
    (B) the medical and patient safety equipment specific to the program;
(8) written operational protocols for the management of equipment, supplies, and medications. These protocols shall include:
    (A) a Specialized Ambulance Protocol Summary document listing of all standard medical equipment, supplies, and medications, approved by the Medical Director as sufficient to manage the anticipated number and severity of injury or illness of the patients, for all vehicles and aircraft used in the program based on the treatment protocols and approved by the OEMS; and
    (B) a methodology to ensure that each ground vehicle and aircraft contains the required equipment, supplies, and medications on each response; and
(9) written policies and procedures specifying how EMS Systems will dispatch and utilize the ground ambulances and aircraft operated by the program.

(b) When transporting patients, staffing for the ground ambulance and aircraft used in the SCTP shall be approved by the SCTP Medical Director as medical crew members, using any of the following as determined by the

transferring physician who is responsible for the medical aspects of the mission to manage the anticipated severity of injury or illness of the patient:

(1) paramedic;
(2) nurse practitioner;
(3) physician;
(4) physician assistant;
(5) registered nurse; or
(6) respiratory therapist.

(c) SCTP as defined in Rule .0102 of this Subchapter are exempt from the staffing requirements defined in G.S. 131E-158(a).

(d) SCTP approval is valid for six years. Programs shall apply to the OEMS for reapproval no more than 90 days prior to expiration.

History Note: Authority G.S. 131E-155.1(b); 131E-158; 143-508;
Temporary Adoption Eff. January 1, 2002;
Eff. January 1, 2004;
Amended Eff. January 1, 2004;
Amended Eff. March 3, 2009 pursuant to E.O. 9, Beverly Perdue, March 3, 2009;
Pursuant to G.S. 150B-21.3(c), a bill was not ratified by the General Assembly to disapprove this rule;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2018.

10A NCAC 13P .0302 AIR MEDICAL SPECIALTY CARE TRANSPORT PROGRAM CRITERIA FOR LICENSED EMS PROVIDERS USING ROTARY-WING AIRCRAFT

(a) Air Medical Programs using rotary-wing aircraft shall document that the program has:

(1) medical crew members that have all completed training regarding:
  (A) altitude physiology; and
  (B) the operation of the EMS communications system used in the program;
(2) written policies and procedures for transporting patients to designated facilities when diversion or bypass plans are activated;
(3) written policies and procedures specifying how EMS Systems will dispatch and utilize aircraft operated by the program;
(4) written triage protocols for trauma, stroke, STEMI, burn, and pediatric patients reviewed and approved by the OEMS Medical Director;
(5) written policies and procedures specifying how EMS Systems will receive the Specialty Care Transport Services offered under the program when the aircraft are unavailable for service; and
(6) written policies and procedures specifying how mutual aid assistance will be obtained from both in-state and bordering out-of-state air medical programs.

(b) All patient response, re-positioning, and mission flight legs shall be conducted under FAA part 135 regulations.

History Note: Authority G.S. 143-508;
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. March 3, 2009 pursuant to E.O. 9, Beverly Perdue, March 3, 2009;
Pursuant to G.S. 150B-21.3(c), a bill was not ratified by the General Assembly to disapprove this rule;
Readopted Eff. January 1, 2017.

10A NCAC 13P .0303 GROUND SPECIALTY CARE TRANSPORT PROGRAMS

10A NCAC 13P .0304 HOSPITAL-AFFILIATED GROUND SPECIALTY CARE TRANSPORT PROGRAMS USED FOR INPATIENT TRANSPORTS

History Note: Authority G.S. 143-508(d)(1); (d)(8); (d)(9);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;

Amended Eff. January 1, 2004;
Repealed Eff. January 1, 2009.

10A NCAC 13P .0305 AIR MEDICAL SPECIALTY CARE TRANSPORT PROGRAM CRITERIA FOR LICENSED EMS PROVIDERS USING FIXED-WING AIRCRAFT

(a) In addition to the general requirements of Specialty Care Transport Programs in Rule .0301 of this Section, Air Medical Programs using fixed-wing aircraft shall document that:

(1) Medical crew members have all completed training regarding:
  (A) Altitude physiology; and
  (B) The operation of the EMS communications system used in the program;
(2) Written policies and procedures specifying how ground ambulance services are utilized by the program for patient delivery and receipt on each end of the transport; and
(3) There is a copy of the Specialty Care Treatment Program patient care protocols.

(b) All patient, re-positioning, and mission flight legs must be conducted under FAA part 135 regulations.

History Note: *Authority G.S. 143-508(d)(1), (d)(3);*
Eff. March 3, 2009 pursuant to E.O. 9, Beverly Perdue, March 3, 2009;
Pursuant to G.S. 150B-21.3(c), a bill was not ratified by the General Assembly to disapprove this rule;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

SECTION .0400 - MEDICAL OVERSIGHT

10A NCAC 13P .0401 COMPONENTS OF MEDICAL OVERSIGHT FOR EMS SYSTEMS

Each EMS System shall have the following components in place to assure medical oversight of the system:

(1) a medical director for adult and pediatric patients appointed, either directly or by written delegation, by the county responsible for establishing the EMS System. Systems may elect to appoint one or more assistant medical directors. The medical director and assistant medical directors shall meet the criteria defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection;"
(2) written treatment protocols for adult and pediatric patients for use by EMS personnel;
(3) for systems providing EMD service, an EMDPRS approved by the medical director;
(4) an EMS Peer Review Committee; and
(5) written procedures for use by EMS personnel to obtain on-line medical direction. On-line medical direction shall:
  (a) be restricted to medical orders that fall within the scope of practice of the EMS personnel and within the scope of approved system treatment protocols;
  (b) be provided only by a physician, EMS-NP, or EMS-PA. Only physicians may deviate from written treatment protocols; and
  (c) be provided by a system of two-way voice communication that can be maintained throughout the treatment and disposition of the patient.

History Note: *Authority G.S. 143-508(b); 143-509(12);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. April 1, 2024.

10A NCAC 13P .0402 COMPONENTS OF MEDICAL OVERSIGHT FOR SPECIALTY CARE TRANSPORT PROGRAMS

Each Specialty Care Transport Program shall have the following components in place to assure Medical Oversight of the system:

(1) a medical director. The administration of the SCTP shall appoint a medical director following the criteria for medical directors of Specialty Care Transport Programs as defined by the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection." The program administration may elect to appoint one or more assistant medical directors;
(2) treatment protocols for adult and pediatric patients for use by medical crew members;
(3) an EMS Peer Review Committee; and
(4) a written protocol for use by medical crew members to obtain on-line medical direction. On-line medical direction shall:
    (a) be restricted to medical orders that fall within the scope of practice of the medical crew members and within the scope of approved program treatment protocols;
    (b) be provided only by a physician, EMS-NP, or EMS-PA. Only physicians may deviate from written treatment protocols; and
    (c) be provided by a system of two-way voice communication that can be maintained throughout the treatment and disposition of the patient.

History Note: Authority G.S. 143-508(b); 143-509(12);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. April 1, 2024.

10A NCAC 13P .0403 RESPONSIBILITIES OF THE MEDICAL DIRECTOR FOR EMS SYSTEMS

(a) The Medical Director for an EMS System is responsible for the following:
(1) ensuring that medical control as set forth in Rule .0401(5) of this Section is available 24 hours a day, seven days a week;
(2) the establishment, approval, and annual updating of adult and pediatric treatment protocols as set forth in Rule .0405 of this Section;
(3) EMD programs, the establishment, approval, and annual updating of the EMDPRS, including subsequent editions published by the EMDPRS program utilized by the EMS System;
(4) medical supervision of the selection, system orientation, continuing education and performance of all EMS personnel;
(5) medical supervision of a scope of practice performance evaluation for all EMS personnel in the system based on the treatment protocols for the system;
(6) the medical review of the care provided to patients;
(7) providing guidance regarding decisions about the equipment, medical supplies, and medications that will be carried on all ambulances and EMS nontransporting vehicles operating within the system;
(8) determining the combination and number of EMS personnel sufficient to manage the anticipated number and severity of injury or illness of the patients transported in Medical Ambulance/Evacuation Bus Vehicles defined in Rule .0219 of this Subchapter; and
(9) keeping the care provided up-to-date with current medical practice.

(b) Any tasks related to Paragraph (a) of this Rule may be completed, through the Medical Director's written delegation, by assisting physicians, physician assistants, nurse practitioners, registered nurses, EMDs, or paramedics.

The EMS System Medical Director may delegate physician medical oversight for a licensed EMS provider at the EMT level of service that does not back up the emergency 911 EMS System. Any decision delegating medical oversight for a licensed provider shall comply with the EMS System franchise requirements in Rule .0204 of this Subchapter. Medical oversight delegated for a licensed EMS provider shall meet the following requirements:
(1) a medical director for adult and pediatric patients. The medical director and assistant medical directors shall meet the criteria defined in "The North Carolina College of Emergency Physicians: Standards for Medical Oversight and Collection;"

(2) treatment protocols must be adopted in their original form from the standard adult and pediatric treatment protocols as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection;" and

(3) establish an agency peer review committee that meets quarterly. The agency peer review committee minutes shall be reported to the EMS System peer review committee.

(c) The Medical Director may suspend temporarily, pending review, any EMS personnel from further participation in the EMS System when he or she determines that the individual's actions are detrimental to the care of the patient, the individual committed unprofessional conduct, or the individual failed to comply with credentialing requirements. During the review process, the Medical Director may:

(1) restrict the EMS personnel's scope of practice pending completion of remediation on the identified deficiencies;

(2) continue the suspension pending completion of remediation on the identified deficiencies; or

(3) permanently revoke the EMS personnel's participation in the EMS System.

History Note: Authority G.S. 143-508(b); 143-508(d)(3); 143-508(d)(7);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024.

10A NCAC 13P .0404 RESPONSIBILITIES OF THE MEDICAL DIRECTOR FOR SPECIALTY CARE TRANSPORT PROGRAMS

(a) The medical director for a Specialty Care Transport Program is responsible for the following:

(1) the establishment, approval, and updating of adult and pediatric treatment protocols as set forth in Rule .0406 of this Section;

(2) medical supervision of the selection, program orientation, continuing education, and performance of medical crew members;

(3) medical supervision of a scope of practice performance evaluation for all medical crew members in the program based on the treatment protocols for the program;

(4) the medical review of the care provided to patients;

(5) keeping the care provided up to date with current medical practice;

(6) approving the Specialized Ambulance Protocol Summary (SAPS) document listing of all medications, equipment, and supplies for all Specialty Care level ground vehicles and aircraft permitted by the OEMS; and

(7) in air medical programs, determination and specification of the medical equipment required in Rule .0209 of this Subchapter that is carried on a mission based on anticipated patient care needs.

(b) Any tasks related to Paragraph (a) of this Rule may be completed, through written delegation, by assisting physicians, physician assistants, nurse practitioners, registered nurses, or medical crew members.

(c) The medical director may suspend temporarily, pending due process review, any medical crew members from further participation in the Specialty Care Transport Program when it is determined the activities or medical care rendered by such personnel may be detrimental to the care of the patient, constitute unprofessional conduct, or result in non-compliance with credentialing requirements. During the review process, the medical director may:

(1) restrict the EMS personnel's scope of practice pending completion of remediation on the identified deficiencies;

(2) continue the suspension pending completion of remediation on the identified deficiencies; or

(3) permanently revoke the EMS personnel's participation in the Specialty Care Transport Program.

History Note: Authority G.S. 143-508(b); 143-509(12);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. April 1, 2024.

10A NCAC 13P .0405 REQUIREMENTS FOR ADULT AND PEDIATRIC TREATMENT PROTOCOLS FOR EMS SYSTEMS

(a) Treatment Protocols used in EMS Systems shall:

(1) Be adopted in their original form from the standard adult and pediatric treatment protocols as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost; and

(2) Not contain medical procedures, medications, or intravenous fluids that exceed the scope of practice defined by the North Carolina Medical Board pursuant to G.S. 143-514 for the level of care offered in the EMS System and any other applicable health care licensing board.

(b) Individual adult and pediatric treatment protocols may be modified locally by EMS Systems if there is a change in a specific protocol which will optimize care within the local community which adds additional medications or medical procedures, or rearranges the order of care provided in the protocol contained within the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection" as described in Paragraph (a) of this Rule. Additional written Treatment Protocols may be developed by any EMS System in addition to the required protocols contained within the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection" as required by the EMS System. All North Carolina College of Emergency Physicians Policies and Procedures must be included and may be modified at the local level. All EMS System Treatment Protocols which have been added or changed by the EMS System shall be submitted to the OEMS Medical Director for review and approval at least 30 days prior to the implementation of the change.

History Note: *Authority G.S. 143-508(b); 143-509(12);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

10A NCAC 13P .0406 REQUIREMENTS FOR ADULT AND PEDIATRIC TREATMENT PROTOCOLS FOR SPECIALTY CARE TRANSPORT PROGRAMS

(a) Adult and pediatric treatment protocols used by medical crew members within a Specialty Care Transport Program shall:

(1) be approved by the OEMS Medical Director and incorporate all skills, medications, equipment, and supplies for Specialty Care Transport Programs as defined by the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost; and

(2) not contain medical procedures, medications, or intravenous fluids that exceed the scope of practice of the medical crew members.

(b) All adult and pediatric treatment protocols shall be reviewed annually, and any change in the treatment protocols shall be submitted to the OEMS Medical Director for review and approval at least 30 days prior to the implementation of the change.

History Note: *Authority G.S. 143-508(b); 143-509(12);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

10A NCAC 13P .0407 REQUIREMENTS FOR EMERGENCY MEDICAL DISPATCH PRIORITY REFERENCE SYSTEM

(a) EMDPRS used by an EMD within an approved EMD program shall:

(1) be approved by the OEMS Medical Director and meet or exceed the statewide standard for EMDPRS as defined by the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection;"
(2) not exceed the EMD scope of practice defined by the North Carolina Medical Board pursuant to G.S. 143-514;
(3) have a written plan how the agency is to maintain a current roster of EMD personnel in the OEMS credentialing and information database;
(4) have a written plan how the emergency medical dispatching agency applying the principles of EMD or offering EMD services, procedures, or program will comply with subsequent editions and compliance standards defined by the EMDPRS program and the EMS System; and
(5) participate and report compliance data at EMS System peer review meetings.

(b) An EMDPRS developed locally shall be reviewed and updated annually and submitted to the OEMS Medical Director for approval. Any change in the EMDPRS shall be submitted to the OEMS Medical Director for review and approval at least 30 days prior to the implementation of the change.

History Note: Authority G.S. 143-508(b); 143-509(12);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. April 1, 2024.

10A NCAC 13P .0408 EMS PEER REVIEW COMMITTEE FOR EMS SYSTEMS

The EMS Peer Review Committee for an EMS System shall:

(1) be composed of membership as defined in G.S. 131E-155(6b).
(2) appoint a physician as chairperson;
(3) meet at least quarterly;
(4) use information gained from the analysis of system data submitted to the OEMS to evaluate the ongoing quality of patient care and medical direction within the system;
(5) use information gained from the analysis of system data submitted to the OEMS to make recommendations regarding the content of continuing education programs for all EMS personnel functioning within the EMS system;
(6) review adult and pediatric treatment protocols of the EMS System and make recommendations to the medical director for changes;
(7) establish and implement a written procedure to guarantee due process reviews for EMS personnel temporarily suspended by the medical director;
(8) record and maintain minutes of committee meetings throughout the approval period of the EMS System;
(9) establish and implement EMS system performance improvement guidelines that meet or exceed the statewide standard as defined by the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost; and
(10) adopt written guidelines that address:
    (a) structure of committee membership;
    (b) appointment of committee officers;
    (c) appointment of committee members;
    (d) length of terms of committee members;
    (e) frequency of attendance of committee members;
    (f) establishment of a quorum for conducting business; and
    (g) confidentiality of medical records and personnel issues.

History Note: Authority G.S. 143-508(b); 143-509(12);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;

Amended Eff. January 1, 2009; January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

10A NCAC 13P .0409 EMS PEER REVIEW COMMITTEE FOR SPECIALTY CARE TRANSPORT PROGRAMS

(a) The EMS Peer Review Committee for a Specialty Care Transport Program shall:

(1) be composed of membership as defined in G.S. 131E-155(6b);
(2) appoint a physician as chairperson;
(3) meet at least quarterly;
(4) analyze program data to evaluate the ongoing quality of patient care and medical direction within the program;
(5) use information gained from program data analysis to make recommendations regarding the content of continuing education programs for medical crew members;
(6) review adult and pediatric treatment protocols of the Specialty Care Transport Programs and make recommendations to the Medical Director for changes;
(7) establish and implement a written procedure to guarantee due process reviews for medical crew members temporarily suspended by the Medical Director;
(8) record and maintain minutes of committee meetings throughout the approval period of the Specialty Care Transport Program;
(9) establish and implement EMS system performance improvement guidelines that meet or exceed the statewide standard as defined by the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection;" and
(10) adopt written guidelines that address:
    (A) structure of committee membership;
    (B) appointment of committee officers;
    (C) appointment of committee members;
    (D) length of terms of committee members;
    (E) frequency of attendance of committee members;
    (F) establishment of a quorum for conducting business; and
    (G) confidentiality of medical records and personnel issues.

(b) County government representation is not required for committee membership for approved Air Medical Programs.

History Note: *Authority G.S. 143-508(b);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2004;
Amended Eff. March 3, 2009 pursuant to E.O. 9, Beverly Perdue, March 3, 2009;
Pursuant to G.S. 150B-21.3(c), a bill was not ratified by the General Assembly to disapprove this rule;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. January 1, 2017.

10A NCAC 13P .0410 COMPONENTS OF MEDICAL OVERSIGHT FOR AIR MEDICAL PROGRAMS

(a) Licensed EMS providers seeking to offer rotary-wing or fixed-wing air medical program services within North Carolina shall receive approval from the OEMS prior to beginning operation.

(b) Licensed EMS providers seeking to offer multiple air medical programs under separate medical oversight processes as set forth in Paragraph (c) of this Rule shall make application for each program and receive approval from the OEMS as set forth in Paragraph (a) of this Rule.

(c) Each Air Medical Program providing services within North Carolina shall meet the following requirements for the provision of medical oversight:

(1) a Medical Director as set forth in Rules .0402 and .0404 of this Section;
(2) treatment protocols approved by the OEMS, to be utilized by the provider as required by Rule .0406 of this Section;

(3) a peer review committee as required by Rule .0409 of this Section;
(4) notify all North Carolina EMS Systems where services will be provided to enable each EMS System to include the provider in their EMS System plan, as set forth in Rule .0201 of this Subchapter;
(5) all aircrafts used within North Carolina shall comply with Rule .0209 of this Subchapter;
(6) populate and maintain a roster in the North Carolina database for all air medical crew members, Medical Directors, and staff identified by the program to serve as primary and secondary administrative contacts;
(7) all medical crew members operating in North Carolina shall maintain a North Carolina license or credential in accordance with the rules and regulations of the respective state licensing or credentialing body;
(8) active membership in each Trauma RAC containing the majority of hospitals where the program transports patients for admission;
(9) submit patient care data electronically, within 24 hours, to the OEMS EMS care database as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Collection" for all interstate and intrastate transports as set forth in Rule .0204 of this Subchapter;
(10) provide information regarding procedures performed during transport within North Carolina to OEMS for quality management review as required by the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection;"
(11) submit peer review materials to the receiving hospital's peer review committee for each patient transported for admission; and
(12) a method providing for the coordinated dispatch of resources between air medical programs for scene safety, ensuring that only the number of air medical resources needed respond to the incident location are provided, and arranging for the receiving hospital to prepare for the incoming patient.

(d) In addition to the requirements set forth in Paragraph (c) of this Rule, Air Medical Program whose base of operation is outside of North Carolina who operate fixed-wing or rotary-wing air medical programs within the State shall meet the following requirements for the provision of medical oversight:

(1) submit to the OEMS all existing treatment protocols utilized by the program in the state that it is based for comparison with North Carolina standards as set forth in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," and make any modifications identified by the OEMS to comply with the standards as set forth in Subparagraph (c)(2) of this Rule;
(2) all aircrafts used within North Carolina shall comply with Rule .0209 of this Subchapter, inspections to be conducted at a location inside North Carolina at a time agreed upon by the Department and the Air Medical Program;
(3) submit written notification to the Department within three business days of receiving notice of any arrests or regulatory investigations for the diversion of drugs or patient care issues involving a North Carolina credentialed or licensed medical crew member; and
(4) any medical crew member suspended by the Department shall be barred from patient contact when operating in North Carolina until such time as the case involving the medical crew member has been adjudicated or resolved as set forth in Rule .1507 of this Subchapter;

(e) Significant failure to comply with the criteria set forth in this Rule shall result in revocation of the Air Medical Program as set forth in Rule .1503 of this Subchapter.

History Note: Authority G.S. 131E-155.1; 131E-156; 131E-157(a); 131E-161; 143-508(d)(8);
Eff. January 1, 2018;
Amended Eff. April 1, 2024.

SECTION .0500 – EMS PERSONNEL

10A NCAC 13P .0501 EDUCATIONAL PROGRAMS

(a) EMS educational programs that qualify credentialed EMS personnel to perform within their scope of practice shall be offered by an EMS educational institution as set forth in Section .0600 of this Subchapter, or by an EMS educational institution in another state where the education and credentialing requirements have been approved for

legal recognition by the Department pursuant to G.S. 131E-159 as determined using the professional judgment of OEMS staff following comparison of out-of-state standards with the program standards set forth in this Rule.
(b) Educational programs approved to qualify EMS personnel for credentialing shall meet the educational content of the "US DOT NHTSA National EMS Education Standards," which is hereby incorporated by reference, including subsequent amendments and editions. This document is available online at no cost at www.ems.gov/education.html.
(c) Educational programs approved to qualify EMS personnel for initial AEMT and Paramedic credentialing shall meet the requirements of Paragraph (b) of this Rule and possess verification of accreditation or a valid letter of review from the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or other accrediting agency determined using the professional judgment of OEMS staff following a comparison of standards. The Department shall not approve initial AEMT or Paramedic courses for educational programs that fail to meet accreditation requirements by January 1, 2023.
(d) Educational programs approved to qualify EMD personnel for credentialing shall conform with the "ASTM F1258 – 95(2014): Standard Practice for Emergency Medical Dispatch," which is hereby incorporated by reference including subsequent amendments and editions. This document is available from ASTM International, 100 Barr Harbor Drive, PO Box C700, West Conshohocken, PA, 19428-2959 USA, at a cost of forty eight dollars ($48.00) per copy.
(e) Instructional methodology courses approved to qualify Level I EMS instructors shall conform with the "US DOT NHTSA 2002 National Guidelines for Educating EMS Instructors," which is hereby incorporated by reference including subsequent amendments and additions. This document is available online at no cost at www.ems.gov/education.html.
(f) Continuing educational programs approved by the OEMS to qualify EMS personnel for renewal of credentials shall be approved by demonstrating the ability to assess cognitive competency in the skills and medications for the level of application as defined by the North Carolina Medical Board pursuant to G.S. 143-514.
(g) Refresher courses shall comply with the requirements defined in Rule .0513 of this Section.

History Note: *Authority G.S. 143-508(d)(3); 143-508(d)(4); 143-514;*
Temporary Adoption Eff. January 1, 2002;
Eff. January 1, 2004;
Amended Eff. January 1, 2009;
Readoption Eff. January 1, 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .0502 INITIAL CREDENTIALING REQUIREMENTS FOR EMR, EMT, AEMT, PARAMEDIC, AND EMD

(a) In order to be credentialed by the OEMS as an EMR, EMT, AEMT, or Paramedic, individuals shall:

(1) Be at least 18 years of age. An examination may be taken at age 17; however, the EMS credential shall not be issued until the applicant has reached the age of 18.

(2) Complete an approved educational program as set forth in Rule .0501 of this Section for their level of application.

(3) Complete a scope of practice performance evaluation that uses performance measures based on the cognitive, psychomotor, and affective educational objectives set forth in Rule .0501 of this Section and that is consistent with their level of application, and approved by the OEMS. This scope of practice evaluation shall be completed no more than one year prior to examination. This evaluation shall be conducted by a Level I or Level II EMS Instructor credentialed at or above the level of application or under the direction of the primary credentialed EMS instructor or educational medical advisor for the approved educational program.

(4) Within 90 days from their course graded date as reflected in the OEMS credentialing database, complete a written examination administered by the OEMS. If the applicant fails to register and complete a written examination within the 90-day period, the applicant shall obtain a letter of authorization to continue eligibility for testing from his or her EMS Educational Institution's program director to qualify for an extension of the 90-day requirement set forth in this Paragraph. If the EMS Educational Institution's program director declines to provide a letter of authorization, the applicant shall be disqualified from completing the credentialing process. Following a review of the applicant's specific circumstances, OEMS staff will determine, based on professional judgment, if the applicant qualifies for EMS credentialing eligibility. The OEMS shall notify the applicant in writing within 10 business days of the decision.

(A) a maximum of three attempts within six months shall be allowed.
(B) if unable to pass the written examination requirement after three attempts, the educational program shall become invalid and the individual may only become eligible for credentialing by repeating the requirements set forth in Rule .0501 of this Section.

(5) Submit to a criminal background history check as set forth in Rule .0511 of this Section.
(6) Submit evidence of completion of all court conditions resulting from any misdemeanor or felony conviction(s).

(b) An individual seeking credentialing as an EMR, EMT, AEMT, or Paramedic may qualify for initial credentialing under the legal recognition option set forth in G.S. 131E-159(c). Individuals seeking credentialing as an AEMT or Paramedic shall submit documentation that the credential being used for application is from an educational program meeting the requirements as set forth in Rule .0501 of this Section. Individuals applying to OEMS for legal recognition, who completed initial educational courses through an OEMS approved North Carolina educational institution, shall complete a written examination administered by the OEMS.

(c) In order to be credentialed by the OEMS as an EMD, individuals shall:

(1) be at least 18 years of age;
(2) complete the educational requirements set forth in Rule .0501 of this Section;
(3) possess a valid CPR card;
(4) submit to a criminal background history check as defined in Rule .0511 of this Section;
(5) submit evidence of completion of all court conditions resulting from any misdemeanor or felony conviction(s); and
(6) possess an EMD nationally recognized credential pursuant to G.S. 131E-159(d).

(d) Pursuant to G.S. 131E-159(h), the Department shall not issue an EMS credential for any person listed on the Department of Public Safety, Sex Offender and Public Protection Registry, or who was convicted of an offense that would have required registration if committed at a time when registration would have been required by law.

History Note: Authority G.S. 131E-159(a); 131E-159(b); 131E-159(g); 131E-159(h); 143-508(d)(3); 143B-952;
Temporary Adoption Eff. January 1, 2002;
Eff. February 1, 2004;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

10A NCAC 13P .0503 TERM OF CREDENTIALS FOR EMS PERSONNEL

EMR, EMT, AEMT, Paramedic, and Instructor credentials shall be valid for a period of four years, and the EMD credential shall be valid for a period of two years, barring any delay in expiration as set forth in Rule .0504 of this Section.

History Note: Authority G.S. 131E-159(a);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. April 1, 2024; January 1, 2017.

10A NCAC 13P .0504 RENEWAL OF CREDENTIALS FOR EMR, EMT, AEMT, PARAMEDIC, AND EMD

(a) EMR, EMT, AEMT, and Paramedic applicants shall renew credentials by meeting the following criteria:

(1) presenting documentation to the OEMS or an approved EMS educational institution or program as set forth in Rule .0601 or .0602 of this Subchapter that they have completed an approved educational program as described in Rule .0501 of this Section;
(2) submit to a criminal background history check as set forth in Rule .0511 of this Section;
(3) submit evidence of completion of all court conditions resulting from applicable misdemeanor or felony conviction(s); and
(4) be a resident of North Carolina or affiliated with an EMS provider approved by the Department.

(b) An individual may renew credentials by presenting documentation to the OEMS that he or she holds a valid EMS credential for his or her level of application issued by the National Registry of Emergency Medical

Technicians or by another state where the education and credentialing requirements have been determined by OEMS staff in their professional judgment to be equivalent to the educations and credentialing requirements set forth in this Section.
(c) EMD applicants shall renew credentials by presenting documentation to the OEMS that he or she holds a valid EMD credential issued by a national credentialing agency using the education criteria set forth in Rule .0501 of this Section.
(d) Upon request, an EMS professional may renew at a lower credentialing level by meeting the requirements defined in Paragraph (a) of this Rule. To restore the credential held at the higher level, the individual shall meet the requirements set forth in Rule .0512 of this Section.
(e) EMS credentials may not be renewed through a local credentialed institution or program more than 90 days prior to the date of expiration.
(f) Pursuant to G.S. 150B-3(a), if an applicant makes a timely and sufficient application for renewal, the EMS credential shall not expire until a decision on the credential is made by the Department. If the application is denied, the credential shall remain effective until the last day for applying for judicial review of the Department's order.
(g) Pursuant to G.S. 131E-159(h), the Department shall not renew the EMS credential for any person listed on the North Carolina Department of Public Safety, Sex Offender and Public Protection Registry, or who was convicted of an offense that would have required registration at a time when registration would have been required by law.

History Note: Authority G.S. 131E-159(a); 131E-159(g); 131E-159(h); 143-508(d)(3); 143B-952; 150B-3(a);
Temporary Adoption Eff. January 1, 2002;
Eff. February 1, 2004;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .0505 SCOPE OF PRACTICE FOR EMS PERSONNEL
EMS Personnel educated in approved programs, credentialed by the OEMS, and functioning under physician medical oversight may perform acts and administer intravenous fluids and medications as allowed by the North Carolina Medical Board pursuant to G.S. 143-514.

History Note: Authority G.S. 143-508(d)(6); 143-514;
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. July 1, 2018.

10A NCAC 13P .0506 PRACTICE SETTINGS FOR EMS PERSONNEL
(a) Credentialed EMS Personnel may function in the following practice settings in accordance with the protocols approved by the OEMS and by the Medical Director of the EMS System or Specialty Care Transport Program with which they are affiliated:
(1) at the location of a physiological or psychological illness or injury;
(2) at public or community health facilities in conjunction with public and community health initiatives;
(3) in hospitals and clinics;
(4) in residences, facilities, or other locations as part of wellness or injury prevention initiatives within the community and the public health system;
(5) at mass gatherings or special events; and
(6) community paramedicine programs.
(b) Individuals functioning in an alternative practice setting as defined in Rule .0102 of this Subchapter consistent with the areas identified in Subparagraphs (a)(1) through (a)(5) of this Rule that are not affiliated with an EMS System shall:
(1) be under the medical oversight of a physician licensed by the North Carolina Medical Board that is associated with the practice setting where the individual will function; and
(2) be restricted to performing within the scope of practice as defined by the North Carolina Medical Board pursuant to G.S. 143-514 for the individual's level of EMS credential.

(c) Individuals holding a valid EMR or EMT credential that are not affiliated with an approved first responder program or EMS agency and that do not administer medications or utilize advanced airway devices are approved to function as a member of an industrial or corporate first aid safety team without medical oversight or EMS System affiliation.

History Note: *Authority G.S. 143-508(d)(7);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. July 1, 2018; January 1, 2017.

10A NCAC 13P .0507 INITIAL CREDENTIALING REQUIREMENTS FOR LEVEL I EMS INSTRUCTORS

(a) Applicants for credentialing as a Level I EMS Instructor shall:

- (1) be currently credentialed by the OEMS as an EMT, AEMT, or Paramedic;
- (2) have completed post-secondary level education equal to or exceeding a minimum of an Associate Degree from an institution accredited by an approved agency listed on the U.S. Department of Education website, www.ed.gov:
  - (A) The Department shall accept degrees from programs accredited by the Accreditation Commission for Education in Nursing (ACEN) and the Commission on Accreditation of Allied Health Education Programs.
  - (B) Additional degrees may be accepted based on the professional judgment of OEMS staff following a comparison of standards;
- (3) have three years experience at the scope of practice for the level of application;
- (4) within one year prior to application, complete an in-person evaluation that demonstrates the applicant's ability to provide didactic and clinical instruction based on the cognitive, psychomotor, and affective educational objectives in Rule .0501 of this Section consistent with their level of application and approved by the OEMS:
  - (A) for a credential to teach at the EMT level, this evaluation shall be conducted under the direction of a Level II EMS Instructor credentialed at or above the level of application; and
  - (B) for a credential to teach at the AEMT or Paramedic level, this evaluation shall be conducted under the direction of the educational medical advisor, or a Level II EMS Instructor credentialed at or above the level of application and designated by the educational medical advisor;
- (5) have 100 hours of teaching experience at or above the level of application in an approved EMS educational program or a program determined by OEMS staff in their professional judgment equivalent to an EMS education program;
- (6) complete an educational program as described in Rule .0501 of this Section; and
- (7) within one year prior to application, attend an OEMS Instructor workshop sponsored by the OEMS. A listing of scheduled OEMS Instructor workshops is available from the OEMS at https://info.ncdhhs.gov/dhsr/ems.

(b) An individual seeking credentialing for Level I EMS Instructor may qualify for initial credentialing under the legal recognition option defined in G.S. 131E-159(c).

(c) The credential of a Level I EMS Instructor shall be valid for four years, or less pursuant to G.S. 131E-159(c), unless any of the following occurs:

- (1) the OEMS imposes an administrative action against the instructor credential; or
- (2) the instructor fails to maintain a current EMT, AEMT, or Paramedic credential at the highest level that the instructor is approved to teach.

(d) Pursuant to the provisions of G.S. 131E-159(h), the Department shall not issue an EMS credential for any person listed on the Department of Public Safety, Sex Offender and Public Protection Registry, or who was convicted of an offense that would have required registration if committed at a time when registration would have been required by law.

History Note: Authority G.S. 131E-159; 143-508(d)(3);
Temporary Adoption Eff. January 1, 2002;
Eff. February 1, 2004;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, 2017;
Amended Eff. January 1, 2022; September 1, 2019.

10A NCAC 13P .0508 INITIAL CREDENTIALING REQUIREMENTS FOR LEVEL II EMS INSTRUCTORS

(a) Applicants for credentialing as a Level II EMS Instructor shall:

(1) be currently credentialed by the OEMS as an EMT, AEMT, or Paramedic;

(2) be currently credentialed by the OEMS as a Level I Instructor at the EMT, AEMT, or Paramedic level;

(3) have completed post-secondary level education equal to or exceeding a Bachelor's Degree from an institution accredited by an approved agency listed on the U.S. Department of Education website, www.ed.gov:

(A) The Department shall accept degrees from programs accredited by the Accreditation Commission for Education in Nursing (ACEN) and the Commission on Accreditation of Allied Health Education Programs.

(B) Additional degrees may be accepted based on the professional judgment of OEMS staff following a comparison of standards;

(4) within one year prior to application, complete an in-person evaluation that demonstrates the applicant's ability to provide didactic and clinical instruction based on the cognitive, psychomotor, and affective educational objectives in Rule .0501 of this Section consistent with their level of application and approved by the OEMS:

(A) for a credential to teach at the EMT level, this evaluation shall be conducted under the direction of a Level II EMS Instructor credentialed at or above the level of application; and

(B) for a credential to teach at the AEMT or Paramedic level, this evaluation shall be conducted under the direction of the educational medical advisor, or a Level II EMS Instructor credentialed at or above the level of application and designated by the educational medical advisor;

(5) a minimum two concurrent years teaching experience as a Level I EMS Instructor at or above the level of application, or as a Level II EMS Instructor at a lesser credential level applying for a higher level in an approved EMS educational program, or teaching experience determined by OEMS staff in their professional judgment to be equivalent to an EMS Level I education program;

(6) complete the "EMS Education Administration Course" conducted by a North Carolina Community College or the National Association of EMS Educators Level II Instructor Course that is valid for the duration of the active Level II Instructor credential; and

(7) within one year prior to application, attend an OEMS Instructor workshop sponsored by the OEMS. A listing of scheduled OEMS Instructor workshops is available from the OEMS at https://info.ncdhhs.gov/dhsr/ems.

(b) An individual seeking credentialing for Level II EMS Instructor may qualify for initial credentialing under the legal recognition option defined in G.S. 131E-159(c).

(c) The credential of a Level II EMS Instructor is valid for four years, or less pursuant to G.S. 131E-159(c), unless any of the following occurs:

(1) the OEMS imposes an administrative action against the instructor credential; or

(2) the instructor fails to maintain a current EMT, AEMT, or Paramedic credential at the highest level that the instructor is approved to teach.

(d) Pursuant to the provisions of G.S. 131E-159(h) the Department shall not issue an EMS credential for any person listed on the Department of Public Safety, Sex Offender and Public Protection Registry, or who was convicted of an offense that would have required registration if committed at a time when registration would have been required by law.

History Note: Authority G.S. 131E-159; 143-508(d)(3);
Temporary Adoption Eff. January 1, 2002;

Eff. February 1, 2004;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, 2017;
Amended Eff. January 1, 2022; September 1, 2019.

10A NCAC 13P .0509 CREDENTIALING OF INDIVIDUALS TO ADMINISTER LIFESAVING TREATMENT TO PERSONS SUFFERING AN ADVERSE REACTION TO AGENTS THAT MIGHT CAUSE ANAPHYLAXIS

(a) To become credentialed by the North Carolina Medical Care Commission to administer epinephrine to persons who suffer adverse reactions to agents that might cause anaphylaxis, a person shall meet the following:

(1) Be 18 years of age or older; and

(2) successfully complete an educational program taught by a physician licensed to practice medicine in North Carolina or designee of the physician. The educational program shall instruct individuals in the appropriate use of procedures for the administration of epinephrine to pediatric and adult victims who suffer adverse reactions to agents that might cause anaphylaxis and shall include the following:

(A) definition of anaphylaxis;

(B) agents that might cause anaphylaxis and the distinction between them, including drugs, insects, foods, and inhalants;

(C) recognition of symptoms of anaphylaxis for both pediatric and adult victims;

(D) appropriate emergency treatment of anaphylaxis as a result of agents that might cause anaphylaxis;

(E) availability and design of packages containing equipment for administering epinephrine to victims suffering from anaphylaxis as a result of agents that might cause anaphylaxis;

(F) pharmacology of epinephrine including indications, contraindications, and side effects;

(G) discussion of legal implications of rendering aid; and

(H) instruction that treatment is to be utilized only in the absence of the availability of physicians or other practitioners who are authorized to administer the treatment.

(b) A credential to administer epinephrine to persons who suffer adverse reactions to agents that might cause anaphylaxis shall be issued by the North Carolina Medical Care Commission upon receipt of a completed application signed by the applicant and the physician who taught or was responsible for the educational program. Applications may be obtained from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707. All credentials shall be valid for a period of four years.

(c) This Rule enables only those individuals who do not hold a North Carolina EMS credential and are not associated or affiliated with an EMS system, EMS agency, or emergency response provider to provide care pending arrival of the emergency responders dispatched through a 911 center to an EMS event involving a person suffering an anaphylactic reaction.

History Note: Authority G.S. 143-508(d)(11); 143-509(9);
Temporary Adoption Eff. January 1, 2003; January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; February 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

10A NCAC 13P .0510 RENEWAL OF CREDENTIALS FOR LEVEL I AND LEVEL II EMS INSTRUCTORS

(a) Level I and Level II EMS Instructor applicants shall renew credentials by presenting documentation to the OEMS that they:

(1) are credentialed by the OEMS as an EMT, AEMT, or Paramedic;

(2) within one year prior to application, complete an evaluation that demonstrates the applicant's ability to provide didactic and clinical instruction based on the cognitive, psychomotor, and affective educational objectives in Rule .0501 of this Section consistent with their level of application and approved by the OEMS:

(A) to renew a credential to teach at the EMT level, this evaluation shall be conducted under the direction of a Level II EMS Instructor credentialed at or above the level of application; and

(B) to renew a credential to teach at the AEMT or Paramedic level, this evaluation shall be conducted under the direction of the educational medical advisor, or a Level II EMS Instructor credentialed at or above the level of application and designated by the educational medical advisor;

(3) completed 96 hours of EMS instruction at the level of application. Individuals identified as EMS program coordinators or positions as determined by OEMS staff in their professional judgment to the equivalent to an EMS program coordinator may provide up to 72 hours related to the institution's needs, with the remaining 24 hours in EMS instruction;

(4) completed 24 hours of educational professional development as defined by the educational institution that provides for:

(A) enrichment of knowledge;

(B) development or change of attitude in students; or

(C) acquisition or improvement of skills; and

(5) within one year prior to renewal application, attend an OEMS Instructor workshop sponsored by the OEMS.

(b) An individual may renew a Level I or Level II EMS Instructor credential under the legal recognition option defined in G.S. 131E-159(c).

(c) The credential of a Level I or Level II EMS Instructor is valid for four years, or less pursuant to G.S. 131E-159(c) unless any of the following occurs:

(1) the OEMS imposes an administrative action against the instructor credential; or

(2) the instructor fails to maintain a current EMT, AEMT, or Paramedic credential at the highest level that the instructor is approved to teach.

(d) Pursuant to the provisions of G.S. 131E-159(h), the Department shall not issue an EMS credential for any person listed on the Department of Public Safety, Sex Offender and Public Protection Registry, or who was convicted of an offense that would have required registration if committed at a time when registration would have been required by law.

History Note: *Authority G.S. 131E-159(a); 131E-159(b); 143-508(d)(3);*
Eff. February 1, 2004;
Amended Eff. February 1, 2009;
Readopted Eff. January 1, 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .0511 CRIMINAL HISTORIES

(a) The criminal background histories for all individuals who apply for, seek to renew, or hold EMS credentials shall be reviewed pursuant to G.S. 131E-159(g).

(b) In addition to Paragraph (a) of this Rule, the OEMS shall carry out the following for all EMS Personnel whose primary residence is outside North Carolina, individuals who have resided in North Carolina for 60 months or less, and individuals under investigation by the OEMS who may be subject to administrative enforcement action by the Department under the provisions of Rule .1507 of this Subchapter:

(1) obtain a signed consent form for a criminal history check;

(2) obtain fingerprints on an SBI identification card or live scan electronic fingerprinting system at an agency approved by the North Carolina Department of Public Safety;

(3) obtain the criminal history from the Department of Public Safety; and

(4) collect any processing fees from the individual identified in Paragraph (a) or (b) of this Rule as required by the Department of Public Safety pursuant to G.S. 143B-952 prior to conducting the criminal history background check.

(c) An individual who makes application for renewal of a current EMS credential or advancement to a higher level EMS credential who has previously submitted a criminal background history required under the criteria contained in Paragraph (b) of this Rule may be exempt from the residency requirements of Paragraph (b) of this Rule if determined by OEMS that no other circumstances warrant another criminal history check as set forth in Paragraph (b) of this Rule.

(d) An individual shall not be eligible for initial or renewal of EMS credentials if the applicant refuses to consent to any criminal history check as required by G.S. 131E-159(g). Since payment is required before the fingerprints may be processed by the Department of Public Safety, failure of the applicant or credentialed EMS personnel to pay the required fee in advance shall be considered a refusal to consent for the purposes of issuance or retention of an EMS credential.

History Note: Authority G.S. 131E-159(g); 143-508(d)(3); 143-508(10); 143B-952;
Eff. January 1, 2009;
Amended Eff. January 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. January 1, 2017.

10A NCAC 13P .0512 REINSTATEMENT OF LAPSED EMS CREDENTIAL

(a) EMS personnel enrolled in an OEMS approved continuing education program as set forth in Rule .0601 of this Subchapter and who were eligible for renewal of an EMS credential prior to expiration, may request the EMS educational institution submit documentation of the continuing education record to the OEMS. OEMS shall renew the EMS credential to be valid for four years from the previous expiration date.
(b) An individual with a lapsed North Carolina EMS credential is eligible for reinstatement through the legal recognition option defined in G.S. 131E-159(c) and Rule .0502 of this Section.
(c) EMR, EMT, AEMT, and Paramedic applicants for reinstatement of an EMS credential, lapsed up to 12 months, shall:

(1) be ineligible for legal recognition pursuant to G.S. 131E-159(c);
(2) be a resident of North Carolina or affiliated with a North Carolina EMS provider or employed with an alternative practice setting in compliance with Rule .0506 of this Section;
(3) at the time of application, present evidence that renewal education requirements were met prior to expiration or complete a refresher course at the level of application taken following expiration of the credential;
(4) complete an OEMS administered written examination for the individual's level of credential application;
(5) undergo a criminal history check performed by the OEMS as defined in Rule .0511 of this Section; and
(6) submit evidence of completion of all court conditions resulting from applicable misdemeanor or felony conviction(s).

(d) EMR, EMT, AEMT, and Paramedic applicants for reinstatement of an EMS credential, lapsed more than 12 months shall:

(1) be ineligible for legal recognition pursuant to G.S. 131E-159(c);
(2) be a resident of North Carolina, affiliated with a North Carolina EMS Provider, or employed with an alternative practice setting in compliance with Rule .0506 of this Section;
(3) at the time of application, complete a refresher course at the level of application taken following expiration of the credential;
(4) complete an OEMS administered written examination for the level of credential application;
(5) undergo a criminal history check performed by the OEMS as defined in Rule .0511 of this Section; and
(6) submit evidence of completion of all court conditions resulting from applicable misdemeanor or felony conviction(s).

(e) EMT, AEMT, and Paramedic applicants for reinstatement of an EMS Instructor Credential, lapsed up to 12 months, shall:

(1) be ineligible for legal recognition pursuant to G.S. 131E-159(c);
(2) be a resident of North Carolina or affiliated with a North Carolina EMS Provider; and
(3) at the time of application, present evidence that renewal requirements were met prior to expiration or within six months following the expiration of the Instructor credential.

(f) EMT, AEMT, and Paramedic applicants for reinstatement of an EMS Instructor credential, lapsed greater than 12 months, shall:

(1) be ineligible for legal recognition pursuant to G.S. 131E-159(c); and

(2) meet the requirements for initial Instructor credentialing set forth in Rules .0507 and .0508 of this Section. Degree requirements that were not applicable to EMS Instructors initially credentialed prior to July 1, 2021 shall be required for reinstatement of a lapsed credential.

(g) EMD applicants shall renew a lapsed credential by meeting the requirements for initial credentialing set forth in Rule .0502 of this Section.

(h) Pursuant to G.S. 131E-159(h), the Department shall not issue or renew an EMS credential for any person listed on the Department of Public Safety, Sex Offender and Public Protection Registry, or who was convicted of an offense that would have required registration if committed at a time when registration would have been required by law.

History Note: *Authority G.S. 131E-159; 143-508(d)(3); 143B-952;*
Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

10A NCAC 13P .0513 REFRESHER COURSES

(a) Approved EMS educational institutions as set forth in Rule .0601 and .0602 of this Subchapter may develop refresher courses for the renewal or reinstatement of EMS credentials.

(b) The application for OEMS approval of a refresher course shall include:

(1) course objectives, content outline, and time allocation to topics of the course;

(2) teaching methodologies for measuring the student's abilities to perform at his or her level of application; and

(3) the method to be used to conduct a technical scope of practice evaluation for students seeking reinstatement of a lapsed EMS credential for their level of application.

(c) EMR, EMT, AEMT and paramedic refresher courses developed for the renewal or reinstatement of an EMS credential shall meet the following criteria:

(1) an application for approval of a refresher course shall be completed at least 30 days prior to the expected date of enrollment and shall include evidence of complying with the requirements of Paragraph (b) of this Rule for refresher courses.

(A) refresher course approval shall be for a period not to exceed two years; and

(B) any changes in curriculum shall be approved by the OEMS prior to implementation.

(2) course curricula shall:

(A) meet the National Registry of Emergency Medical Technicians' recertification requirements, which is hereby incorporated by reference including subsequent amendments and additions. This document is available from the National Registry of Emergency Medical Technicians, online at www.nremt.org/rwd/public/document/recertification at no cost; and

(B) demonstrate the ability to assess student knowledge and competency in the skills and medications as defined by the North Carolina Medical Board pursuant to G.S. 143-514 for the proposed level of EMS credential application.

History Note: *Authority G.S. 143-508(d)(3); 143B-952;*
Eff. January 1, 2017.

SECTION .0600 – EMS EDUCATIONAL INSTITUTIONS AND PROGRAMS

10A NCAC 13P .0601 CONTINUING EDUCATION EMS EDUCATIONAL PROGRAM REQUIREMENTS

(a) Continuing Education EMS Educational Programs shall be credentialed by the OEMS to provide only EMS continuing education. An application for credentialing as an approved EMS continuing education program shall be submitted to the OEMS for review.

(b) Continuing Education EMS Educational Programs shall have:

(1) at least a Level I EMS Instructor as program coordinator and shall hold a Level I EMS Instructor credential at a level equal to or greater than the highest level of continuing education program offered in the EMS System, Specialty Care Transport Program, or Agency;

(2) a continuing education program shall be consistent with the services offered by the EMS System, Specialty Care Transport Program, or Agency;

(A) In an EMS System, the continuing education programs shall be reviewed and approved by the system continuing education director and Medical Director;
(B) In a Specialty Care Transport Program, the continuing education program shall be reviewed and approved by Specialty Care Transport Program Continuing Education director and the Medical Director; and
(C) In an Agency not affiliated with an EMS System or Specialty Care Transport Program, the continuing education program shall be reviewed and approved by the Agency Program Medical Director;

(3) written educational policies and procedures to include each of the following;
(A) the delivery of educational programs in a manner where the content and material is delivered to the intended audience, with a limited potential for exploitation of such content and material;
(B) the record-keeping system of student attendance and performance;
(C) the selection and monitoring of EMS instructors; and
(D) student evaluations of faculty and the program's courses or components, and the frequency of the evaluations;

(4) access to instructional supplies and equipment necessary for students to complete educational programs as defined in Rule .0501 of this Subchapter;
(5) meet the educational program requirements as defined in Rule .0501 of this Subchapter;
(6) Upon request, the approved EMS continuing education program shall provide records to the OEMS in order to verify compliance and student eligibility for credentialing; and
(7) approved education program credentials are valid for a period not to exceed four years.

(c) Program directors shall attend an OEMS Program Coordinator workshop annually. A listing of scheduled OEMS Program Director Workshops is available at https://emspic.org. Newly appointed program directors who have not attended an OEMS Program Director Workshop within the past year shall attend a workshop within one year of appointment as the program director.

(d) Assisting physicians delegated by the EMS System Medical Director as authorized by Rule .0403 of this Subchapter or SCTP Medical Director as authorized by Rule .0404 of this Subchapter for provision of medical oversight of continuing education programs shall meet the Education Medical Advisor criteria as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight."

History Note: *Authority G.S. 143-508(d)(4); 143-508(d)(13);*
Temporary Adoption Eff. January 1, 2002;
Eff. January 1, 2004;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

10A NCAC 13P .0602 BASIC AND ADVANCED EMS EDUCATIONAL INSTITUTION REQUIREMENTS

(a) Basic and Advanced EMS Educational Institutions may offer educational programs for which they have been credentialed by the OEMS.

(1) EMS Educational Institutions shall complete a minimum of two initial courses at the highest level educational program approved for the Educational Institution's credential approval period.
(2) EMS Educational Institutions that do not complete two initial courses for each educational program approved shall be subject to action as set forth in Rule .1505 of this Subchapter.

(b) For initial courses, Basic EMS Educational Institutions shall meet all of the requirements for continuing EMS educational programs defined in Rule .0601 of this Section and shall have:

(1) a Level I or higher EMS Instructor as each lead course instructor for all courses. The lead course instructor must be credentialed at a level equal to or higher than the course and shall meet the lead instructor responsibilities of the CAAHEP Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions as set forth in Rule .0501 of this Subchapter. The lead instructor shall:
(A) perform duties assigned under the direction and delegation of the program director.
(B) assist in coordination of the didactic, lab, clinical, and field internship instruction.

(2) a lead EMS educational program director. This individual shall be a Level II EMS Instructor credentialed at or above the highest level of course offered by the institution. Newly appointed program directors who have not attended an OEMS Program Coordinator Workshop with the past year shall attend a workshop within one year of appointment as the program director; and:
  (A) have EMS or related allied health education, training, and experience;
  (B) be knowledgeable about methods of instruction, testing, and evaluation of students;
  (C) have field experience in the delivery of pre-hospital emergency care;
  (D) have academic training and preparation related to emergency medical services, at least equivalent to that of a paramedic; and
  (E) be knowledgeable of current versions of the National EMS Scope of Practice and National EMS Education Standards as defined by USDOT NHTSA National EMS, evidence-informed clinical practice, and incorporated by Rule .0501 of this Subchapter;
(3) a lead EMS educational program director responsible for the following:
  (A) the administrative oversight, organization, and supervision of the program;
  (B) the continuous quality review and improvement of the program;
  (C) the long-range planning on ongoing development of the program;
  (D) evaluating the effectiveness of the instruction, faculty, and overall program;
  (E) the collaborative involvement with the Education Medical Advisor;
  (F) the training and supervision of clinical and field internship preceptors; and
  (G) the effectiveness and quality of fulfillment of responsibilities delegated to another qualified individual;
(4) written educational policies and procedures that include:
  (A) the written educational policies and procedures set forth in Rule .0601 of this Section;
  (B) the delivery of cognitive and psychomotor examinations in a manner that will protect and limit the potential for exploitation of such content and material;
  (C) the exam item validation process utilized for the development of validated cognitive examinations;
  (D) the selection and monitoring of all in-state and out-of-state clinical education and field internship sites;
  (E) the selection and monitoring of all educational institutionally approved clinical education and field internship preceptors;
  (F) utilization of EMS preceptors providing feedback to the student and EMS program;
  (G) the evaluation of preceptors by their students, including the frequency of evaluations;
  (H) the evaluation of the clinical education and field internship sites by their students, including the frequency of evaluations;
  (I) completion of an annual evaluation of the program to identify any correctable deficiencies;
  (J) the program annually assesses goals and learning domains that include how program staff identify and respond to changes in the needs or expectations of the community's interests; and
  (K) an advisory committee representing all practice settings utilizing EMS personnel, including clinical preceptor sites, shall assist the program to monitor community needs and expectations and provide guidance to revise goals and responsiveness to change. The advisory committee shall meet no less than annually.
(5) an Educational Medical Advisor that meets the criteria as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection" who is responsible for the following;
  (A) medical oversight of the program;
  (B) collaboration to provide appropriate and updated educational content for the program curriculum;
  (C) establishing minimum requirements for program completion;
  (D) oversight of student evaluation, monitoring, and remediation as needed;
  (E) ensuring entry level competence;
  (F) ensuring interaction of physician and students; and

(6) written educational policies and procedures describing the delivery of educational programs, the record-keeping system detailing student attendance and performance, and the selection and monitoring of EMS instructors.

(c) For initial courses, Advanced Educational Institutions shall meet all requirements set forth in Paragraph (b) of this Rule, Standard III of the CAAHEP Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions shall apply, and;

(1) The faculty must be knowledgeable in course content and effective in teaching their assigned subjects, and capable through academic preparation, training, and experience to teach the courses or topics to which they are assigned.

(2) A faculty member to assist in teaching and clinical coordination in addition to the program coordinator.

(d) The educational institution shall notify the OEMS within 10 business days of a change to the program director or Medical Advisor position. The educational institution shall submit the change to the OEMS as an addendum to the approved Educational Institution application within 30 days of the effective date of the position change.

(e) Basic and Advanced EMS Educational Institution credentials shall be valid for a period of four years, unless the institution is accredited in accordance with Rule .0605 of this Section.

History Note: Authority G.S. 143-508(d)(4); 143-508(d)(13);
Temporary Adoption Eff. January 1, 2002;
Eff. January 1, 2004;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

10A NCAC 13P .0603 ADVANCED EMS EDUCATIONAL INSTITUTION REQUIREMENTS

History Note: Authority G.S. 143-508(d)(4); 143-508(d)(13);
Temporary Adoption Eff. January 1, 2002;
Eff. February 1, 2004;
Amended Eff. January 1, 2009;
Repealed Eff. January 1, 2017.

10A NCAC 13P .0604 TRANSITION FOR APPROVED TEACHING INSTITUTIONS

History Note: Authority G.S. 143-508(b);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Repealed Eff. January 1, 2004.

10A NCAC 13P .0605 ACCREDITED EMS EDUCATIONAL INSTITUTION REQUIREMENTS

(a) EMS Educational Institutions who already possess accreditation by the CAAHEP shall be credentialed by the OEMS by presenting:

(1) an application for credentialing;
(2) evidence of current CAAHEP accreditation;
(3) a copy of the self study;
(4) a copy of the executive analysis; and
(5) documentation reflecting compliance with Rule .0602(b) and (c) of this Section.

(b) Accredited EMS Educational Institutions may offer initial and renewal educational programs for EMS personnel as defined in Rule .0501 of this Subchapter.

(c) Accredited EMS Educational Institutions maintaining CAAHEP accreditation shall renew credentials no more than 12 months prior to expiration of the OEMS credentials by providing the information detailed in Paragraph (a) of this Rule.

(d) Accredited EMS Educational Institutions that fail to maintain CAAHEP accreditation shall be subject to the credentialing and renewal criteria set forth in Rule .0602 of this Section.

(e) Accredited EMS Educational Institution credentials are valid for a period of five years.

History Note: Authority G.S. 143-508(d)(4); 143-508(d)(13);
Eff. January 1, 2017.

SECTION .0700 - ENFORCEMENT

10A NCAC 13P .0701 DENIAL, SUSPENSION, AMENDMENT OR REVOCATION

History Note: Authority G.S. 131E-155.1(d); 131E-157(c); 131E-159(a),(f); 131E-162; 143-508(d)(10);
Temporary Adoption Eff. January 1, 2002;
Eff. January 1, 2004;
Amended Eff. January 1, 2009;
Repealed Eff. January 1, 2013.

10A NCAC 13P .0702 PROCEDURES FOR DENIAL, SUSPENSION, AMENDMENT, OR REVOCATION

History Note: Authority G.S. 143-508(d)(10);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Repealed Eff. January 1, 2013.

SECTION .0800 – TRAUMA SYSTEM DEFINITIONS

10A NCAC 13P .0801 TRAUMA SYSTEM DEFINITIONS

History Note: Authority G.S. 131E-162;
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Repealed Eff. January 1, 2009.

SECTION .0900 - TRAUMA CENTER STANDARDS AND APPROVAL

10A NCAC 13P .0901 TRAUMA CENTER CRITERIA

To receive designation as a Level I, Level II, or Level III Trauma Center, a hospital shall:

(1) have a trauma program and a trauma service that have been operational for at least 12 months prior to application for designation;

(2) at least 12 months prior to submitting a RFP, have membership in and inclusion of all trauma patient records in the North Carolina Trauma Registry, in accordance with the North Carolina Trauma Registry Data Dictionary incorporated by reference including subsequent amendments and editions. This document is available from the OEMS online at https://info.ncdhhs.gov/dhsr/EMS/trauma/traumaregistry.html at no cost;

(3) meet the verification criteria for designation as a Level I, Level II, or Level III Trauma Center, as defined in the "American College of Surgeons: Resources for Optimal Care of the Injured Patient," which is hereby incorporated by reference, including subsequent amendments and editions. This document can be downloaded at no cost online at www.facs.org; and

(4) meet all requirements of the designation level applied for initial designation set forth in Rule .0904 of this Section or for renewal designation set forth in Rule .0905 of this Section.

History Note: Authority G.S. 131E-162; 143-508(d)(2);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Readopted Eff. January 1, 2017;
Amended Eff. September 1, 2019.

10A NCAC 13P .0902 LEVEL II TRAUMA CENTER CRITERIA

10A NCAC 13P .0903 LEVEL III TRAUMA CENTER CRITERIA

History Note: Authority G.S. 131E-162;
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Repealed Eff. January 1, 2017.

10A NCAC 13P .0904 INITIAL DESIGNATION PROCESS

(a) For initial Trauma Center designation or changing the level of Trauma Center designation, the hospital shall request a consult visit by OEMS and the consult shall occur within one year prior to submission of the RFP.

(b) A hospital interested in pursuing Trauma Center designation shall submit a letter of intent 180 days prior to the submission of an RFP to the OEMS. The letter shall define the hospital's primary trauma catchment area. Simultaneously, Level I or II applicants shall also demonstrate the need for the Trauma Center designation by submitting one original and three copies of documents that include:

(1) the population to be served and the extent that the population is underserved for trauma care with the methodology used to reach this conclusion;

(2) geographic considerations, to include trauma primary and secondary catchment area and distance from other Trauma Centers; and

(3) evidence the Trauma Center will admit 1200 or more trauma patients annually or show that its trauma service will be taking care of at least 240 trauma patients with an ISS greater than or equal to 15 yearly. These criteria shall be met without compromising the quality of care or cost effectiveness of any other designated Level I or II Trauma Center sharing all or part of its catchment area or by jeopardizing the existing Trauma Center's ability to meet this same 240-patient minimum.

(c) The hospital shall be participating in the State Trauma Registry as defined in Rule .0102 of this Subchapter, and submit data weekly to the OEMS of 12 months or more prior to application that includes all the Trauma Center's trauma patients as defined in Rule .0102 of this Subchapter who are:

(1) diverted to an affiliated hospital;

(2) admitted to the Trauma Center for greater than 24 hours from an ED or hospital;

(3) die in the ED;

(4) are DOA; or

(5) are transferred from the ED to the OR, ICU, or another hospital (including transfer to any affiliated hospital).

(d) OEMS shall review the regional Trauma Registry data from both the applicant and the existing trauma center(s), and ascertain the applicant's ability to satisfy the justification of need information required in Paragraph (b) of this Rule. The OEMS shall notify the applicant's primary RAC of the application and provide the regional data submitted by the applicant in Paragraph (b) of this Rule for review and comment. The RAC shall be given 30 days to submit written comments to the OEMS.

(e) OEMS shall notify the respective Board of County Commissioners in the applicant's primary catchment area of the request for initial designation to allow for comment during the same 30 day comment period.

(f) OEMS shall notify the hospital in writing of its decision to allow submission of an RFP. If approved, the RAC and Board of County Commissioners in the applicant's primary catchment area shall also be notified by the OEMS that an RFP will be submitted.

(g) Once the hospital is notified that an RFP will be accepted, the hospital shall complete and submit an electronic copy of the completed RFP with signatures to the OEMS no later than 45 days prior to the proposed site visit date.

(h) The RFP shall demonstrate that the hospital meets the standards for the designation level applied for as found in Rule .0901 of this Section.

(i) If OEMS does not recommend a site visit based upon failure to comply with Rule .0901 of this Section, the OEMS shall send the written reasons to the hospital within 30 days of the decision. The hospital may reapply for designation within six months following the submission of an updated RFP. If the hospital fails to respond within six months, the hospital shall reapply following the process outlined in Paragraphs (a) through (h) of this Rule.

(j) If after review of the RFP, the OEMS recommends the hospital for a site visit, the OEMS shall notify the hospital within 30 days. The hospital and the OEMS shall agree on the date of the site visit.

(k) Except for OEMS representatives, reviewers for a Level I or II visit shall be from outside the local or adjacent RAC, unless mutually agreed upon by the OEMS and the trauma center seeking designation where the hospital is located. The composition of a Level I or II site survey team shall be as follows:

(1) one trauma surgeon who is a Fellow of the ACS, experienced as a site surveyor, who shall be the primary reviewer;
(2) one emergency physician who currently works in a designated trauma center, is a member of the American College of Emergency Physicians or American Academy of Emergency Medicine, and is boarded in emergency medicine by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
(3) one trauma surgeon;
(4) one trauma program manager; and
(5) OEMS Staff.

(l) All site team members for a Level III visit except for the OEMS representatives, shall be from outside the local or adjacent RAC where the hospital is located. The composition of a Level III state site survey team shall be as follows:

(1) one trauma surgeon who is a Fellow of the ACS and shall be the primary reviewer;
(2) one emergency physician who currently works in a designated trauma center and is boarded in emergency medicine by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
(3) one trauma program manager; and
(4) OEMS Staff.

(m) The hospital shall make available all requested patient medical charts.

(n) The primary reviewer of the site review team shall give a verbal post-conference report representing a consensus of the site review team. The primary reviewer shall complete and submit to the OEMS a written consensus report within 30 days of the site visit.

(o) The report of the site survey team and the staff recommendations shall be reviewed by the State Emergency Medical Services Advisory Council at its next regularly scheduled meeting following the site visit. Based upon the site visit report and the staff recommendation, the State Emergency Medical Services Advisory Council shall recommend to the OEMS that the request for Trauma Center designation be approved or denied.

(p) All criteria defined in Rule .0901 of this Section shall be met for initial designation at the level requested.

(q) Hospitals with a deficiency(ies) resulting from the site visit shall be given up to 12 months to demonstrate compliance. Satisfaction of deficiency(ies) may require an additional site visit. The need for an additional site visit shall be determined on a case-by-case basis based on the type of deficiency. If compliance is not demonstrated within the time period set by OEMS, the hospital shall submit a new application and updated RFP and follow the process outlined in Paragraphs (a) through (h) of this Rule.

(r) The final decision regarding Trauma Center designation shall be rendered by the OEMS.

(s) The OEMS shall notify the hospital in writing of the State Emergency Medical Services Advisory Council's and OEMS' final recommendation within 30 days of the Advisory Council meeting.

(t) If a trauma center changes its trauma program administrative structure such that the trauma service, trauma Medical Director, trauma program manager, or trauma registrar are relocated on the hospital's organizational chart at any time, it shall notify OEMS of this change in writing within 30 days of the occurrence.

(u) Initial designation as a trauma center shall be valid for a period of three years.

History Note: *Authority G.S. 131E-162; 143-508(d)(2);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2018.

10A NCAC 13P .0905 RENEWAL DESIGNATION PROCESS

(a) Hospitals may utilize one of two options to achieve Trauma Center renewal:

(1) undergo a site visit conducted by OEMS to obtain a four-year renewal designation; or
(2) undergo a verification visit by the ACS, in conjunction with the OEMS, to obtain a three-year renewal designation.

(b) For hospitals choosing Subparagraph (a)(1) of this Rule:

(1) prior to the end of the designation period, the OEMS shall forward to the hospital an RFP for completion. The hospital shall, within 10 business days of receipt of the RFP, define for OEMS the Trauma Center's trauma primary catchment area.

(2) hospitals shall complete and submit an electronic copy of the RFP to the OEMS and the specified site surveyors at least 30 days prior to the site visit. The RFP shall include information that supports compliance with the criteria contained in Rule .0901 of this Section as it relates to the Trauma Center's level of designation.

(3) all criteria defined in Rule .0901 of this Section, as it relates to the Trauma Center's level of designation, shall be met for renewal designation.

(4) a site visit shall be conducted within 120 days prior to the end of the designation period. The hospital and the OEMS shall agree on the date of the site visit.

(5) the composition of a Level I or II site survey team shall be the same as that specified in Rule .0904 of this Section.

(6) the composition of a Level III site survey team shall be the same as that specified in Rule .0904 of this Section.

(7) on the day of the site visit, the hospital shall make available all requested patient medical charts.

(8) the primary reviewer of the site review team shall give a verbal post-conference report representing a consensus of the site review team. The primary reviewer shall complete and submit to the OEMS a written consensus report within 30 days of the site visit.

(9) the report of the site survey team and a staff recommendation shall be reviewed by the NC Emergency Medical Services Advisory Council at its next regularly scheduled meeting following the site visit. Based upon the site visit report and the staff recommendation, the NC Emergency Medical Services Advisory Council shall recommend to the OEMS that the request for Trauma Center renewal be:

  (A) approved;
  (B) approved with a contingency(ies) due to a deficiency(ies) requiring a focused review;
  (C) approved with a contingency(ies) not due to a deficiency(ies) requiring a consultative visit; or
  (D) denied.

(10) hospitals with a deficiency(ies) shall have up to 10 business days prior to the NC Emergency Medical Services Advisory Council meeting to provide documentation to demonstrate compliance. If the hospital has a deficiency that cannot be corrected in this period prior to the NC Emergency Medical Services Advisory Council meeting, the hospital shall be given 12 months by the OEMS to demonstrate compliance and undergo a focused review that may require an additional site visit. The need for an additional site visit is on a case-by-case basis based on the type of deficiency. The hospital shall retain its Trauma Center designation during the focused review period. If compliance is demonstrated within the prescribed time period, the hospital shall be granted its designation for the four-year period from the previous designation's expiration date. If compliance is not demonstrated within the 12 month time period, the Trauma Center designation shall not be renewed. To become redesignated, the hospital shall submit an updated RFP and follow the initial applicant process outlined in Rule .0904 of this Section.

(11) the final decision regarding trauma center renewal shall be rendered by the OEMS.

(12) the OEMS shall notify the hospital in writing of the NC Emergency Medical Services Advisory Council's and OEMS' final recommendation within 30 days of the NC Emergency Medical Services Advisory Council meeting.

(13) hospitals with a deficiency(ies) shall submit an action plan to the OEMS to address the deficiency(ies) within 10 business days following receipt of the written final decision on the trauma recommendations.

(c) For hospitals choosing Subparagraph (a)(2) of this Rule:

(1) at least six months prior to the end of the Trauma Center's designation period, the trauma center shall notify the OEMS of its intent to undergo an ACS verification visit. It shall simultaneously define in writing to the OEMS its trauma primary catchment area. Trauma Centers choosing this option shall then comply with all the ACS' verification procedures, as well as any additional state criteria as defined in Rule .0901 of this Section, that apply to their level of designation.

(2) when completing the ACS' documentation for verification, the Trauma Center shall ensure access to the ACS on-line PRQ (pre-review questionnaire) to OEMS. The Trauma Center shall simultaneously complete any documents supplied by OEMS and forward these to the OEMS.

(3) the Trauma Center shall make sure the site visit is scheduled to ensure that the ACS' final written report, accompanying medical record reviews and cover letter are received by OEMS at least 30 days prior to a regularly scheduled NC Emergency Medical Services Advisory Council meeting to ensure that the Trauma Center's state designation period does not terminate without consideration by the NC Emergency Medical Services Advisory Council.

(4) any in-state review for a hospital choosing Subparagraph (a)(2) of this Rule, except for the OEMS staff, shall be from outside the local or adjacent RAC in which the hospital is located.

(5) the composition of a Level I, II, or III site survey team for hospitals choosing Subparagraph (a)(2) of this Rule shall be as follows:

(A) one trauma surgeon who is a Fellow of the ACS, experienced as a site surveyor, who shall be the primary reviewer;

(B) one emergency physician who works in a designated trauma center, is a member of the American College of Emergency Physicians or the American Academy of Emergency Medicine, and is boarded in emergency medicine by the American Board of Emergency Physicians or the American Osteopathic Board of Emergency Medicine;

(C) one trauma program manager; and

(D) OEMS staff.

(6) the date, time, and all proposed members of the site visit team shall be submitted to the OEMS for review at least 45 days prior to the site visit. The OEMS shall approve the site visit schedule if the schedule does not conflict with the ability of attendance by required OEMS staff. The OEMS shall approve the proposed site visit team members if the OEMS determines there is no conflict of interest, such as previous employment, by any site visit team member associated with the site visit.

(7) all state Trauma Center criteria shall be met as defined in Rule .0901 of this Section for renewal of state designation. ACS' verification is not required for state designation. ACS' verification does not ensure a state designation.

(8) The ACS final written report and supporting documentation described in Subparagraph (c)(4) of this Rule shall be used to generate a report following the post conference meeting for presentation to the NC Emergency Medical Services Advisory Council for renewal designation.

(9) the final written report issued by the ACS' verification review committee, the accompanying medical record reviews from which all identifiers shall be removed and cover letter shall be forwarded to OEMS within 10 business days of its receipt by the Trauma Center seeking renewal.

(10) the OEMS shall present its summary of findings report to the NC Emergency Medical Services Advisory Council at its next regularly scheduled meeting. The NC Emergency Medical Services Advisory Council shall recommend to the Chief of the OEMS that the request for Trauma Center renewal be:

(A) approved;

(B) approved with a contingency(ies) due to a deficiency(ies) requiring a focused review;

(C) approved with a contingency(ies) not due to a deficiency(ies); or

(D) denied.

(11) the OEMS shall send the hospital written notice of the NC Emergency Medical Services Advisory Council's and OEMS' final recommendation within 30 days of the NC Emergency Medical Services Advisory Council meeting.

(12) the final decision regarding trauma center designation shall be rendered by the OEMS.

(13) hospitals with contingencies as the result of a deficiency(ies), as determined by OEMS, shall have up to 10 business days prior to the NC Emergency Medical Services Advisory Council meeting to provide documentation to demonstrate compliance. If the hospital has a deficiency that cannot be corrected in this time period, the hospital, may undergo a focused review to be conducted by the OEMS whereby the Trauma Center shall be given 12 months by the OEMS to demonstrate compliance. Satisfaction of contingency(ies) may require an additional site visit. The need for an additional site visit is on a case-by-case basis based on the type of deficiency. The hospital shall retain its Trauma Center designation during the focused review period. If compliance is demonstrated within the prescribed time period, the hospital shall be granted its designation for the three-year period from the previous designation's expiration date. If compliance is not

demonstrated within the 12 month time period, the Trauma Center designation shall not be renewed. To become redesignated, the hospital shall submit a new RFP and follow the initial applicant process outlined in Rule .0904 of this Section.

(14) hospitals with a deficiency(ies) shall submit an action plan to the OEMS to address the deficiency(ies) within 10 business days following receipt of the written final decision on the trauma recommendations.

(d) If a Trauma Center currently using the ACS' verification process chooses not to renew using this process, it must notify the OEMS at least six months prior to the end of its state trauma center designation period of its intention to exercise the option in Subparagraph (a)(1) of this Rule. Upon notification, the OEMS shall extend the designation for one additional year to ensure consistency with hospitals using Subparagraph (a)(1) of this Rule.

History Note: *Authority G.S. 131E-162; 143-508(d)(2);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. April 1, 2009; January 1, 2009; January 1, 2004;
Readoption Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

SECTION .1000 – TRAUMA CENTER DESIGNATION ENFORCEMENT

10A NCAC 13P .1001 DENIAL, FOCUSED REVIEW, VOLUNTARY WITHDRAWAL, OR REVOCATION OF TRAUMA CENTER DESIGNATION
10A NCAC 13P .1002 PROCEDURES FOR APPEAL OF DENIAL, FOCUSED REVIEW, OR REVOCATION

History Note: *Authority G.S. 131E-162;*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Repealed Eff. January 1, 2009.

10A NCAC 13P .1003 MISREPRESENTATION OF DESIGNATION

(a) Hospitals shall not represent themselves as trauma centers unless they are currently designated by the Department pursuant to Section .0900 of this Subchapter.

(b) Designation applies only to the hospital that submitted the RFP and underwent the formal site survey and does not extend to its satellite facilities or affiliates.

History Note: *Authority G.S. 131E-162;*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

SECTION .1100 - TRAUMA SYSTEM DESIGN

10A NCAC 13P .1101 STATE TRAUMA SYSTEM

(a) The State trauma system shall consist of regional plans, policies, guidelines, and performance improvement initiatives by the RACs to create an Inclusive Trauma System monitored by the OEMS.

(b) Each hospital and EMS System shall affiliate as defined in Rule .0102 of this Subchapter and participate with the RAC that includes the Level I or II Trauma Center where the majority of trauma patient referrals and transports occur. Each hospital and EMS System shall submit to the OEMS upon request patient transfer patterns from data sources that support the choice of their primary RAC affiliation. Each RAC shall include at least one Level I or II Trauma Center.

(c) Each Lead RAC Coordinator shall update and submit RAC affiliation membership for hospitals and EMS Systems to the OEMS no later than July 1 of each year. Each hospital or EMS System shall submit written notification to the OEMS for any RAC affiliation change. RAC affiliation may be changed only if supported by a

change in the majority of transfer patterns to a Level I or Level II Trauma Center. Documentation of these new transfer patterns shall be included in the request to change affiliation.

History Note: Authority G.S. 131E-162;
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. July 1, 2021; January 1, 2017.

10A NCAC 13P .1102 REGIONAL TRAUMA SYSTEM PLAN

(a) After consultation with all Level I and II Trauma Centers within their catchment areas, a Level I or II Trauma Center shall be selected as the lead RAC agency by the OEMS to facilitate development of and provide RAC staff support that includes the following:

(1) the trauma Medical Director(s) from the lead RAC agency;
(2) a trauma nurse coordinator(s) or program manager(s) from the lead RAC agency; and
(3) an individual to coordinate RAC activities.

(b) The RAC membership shall include the following:

(1) the trauma Medical Director(s) and the trauma nurse coordinator(s) or program manager(s) from the lead RAC agency;
(2) if on staff, the outreach coordinator(s), or designee(s) from the lead RAC agency;
(3) if on staff, an injury prevention coordinator(s), or designees(s) from the lead RAC agency;
(4) the RAC registrar or designee(s) from the lead RAC agency;
(5) a senior level hospital administrator from the lead RAC agency;
(6) an emergency physician from the lead RAC agency;
(7) a representative from each EMS system participating in the RAC;
(8) a representative from each hospital participating in the RAC;
(9) community representatives from the lead RAC agency's catchment area; and
(10) An EMS System Medical Director or Assistant Medical Director from the lead RAC agency's catchment area.

(c) The lead RAC agency shall develop a plan within one year of notification of the RAC membership a regional trauma system plan containing:

(1) organizational structures, including the roles of the members of the system;
(2) goals and objectives, including the orientation of the providers to the regional system;
(3) RAC membership list, rules of order, terms of office, and meeting schedule. Meetings shall be held at least two times per year;
(4) information required by the OEMS as set forth in Rule .1103 of this Section;
(5) the regional trauma system evaluation tools to be utilized;
(6) written verification of regional support from members of the RAC for the regional trauma system plan; and
(7) performance improvement activities, including utilization of regional trauma system patient care data.

(d) The RAC shall prepare an annual progress report no later than July 1 of each year that assesses compliance with the regional trauma system plan and specifies any updates to the plan. This report shall be made available to the OEMS for review upon request.

(e) Upon OEMS' receipt of a letter of intent for initial Level I or II Trauma Center designation by a hospital in the lead RAC agency's catchment area as set forth in Rule .0904(b) of this Subchapter, the applicant's lead RAC agency shall be provided the applicant's data from the OEMS for distribution to all RAC members for review and comment, as set forth in Rule .0904(d) of this Subchapter.

(f) The RAC membership has 30 days to comment on the request for initial designation. All comments shall be sent from each RAC member directly to the OEMS, with the lead RAC agency provided a copy of their response, within this 30 day comment period.

(g) The OEMS shall notify the regional RAC of the OEMS approval of a hospital to submit an RFP for trauma center designation.

History Note: *Authority G.S. 131E-162; 143-508(d)(5); 143-508(d)(12);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. January 1, 2017.

10A NCAC 13P .1103 REGIONAL TRAUMA SYSTEM POLICY DEVELOPMENT

The RAC shall oversee the development, implementation, and evaluation of the regional trauma system that includes:

(1) A public information and education program to include system access and injury prevention;
(2) Written trauma system guidelines addressing the following:
   (a) Regional communications;
   (b) Triage;
   (c) Treatment at the accident scene, and in the pre-hospital, inter-hospital, and Emergency Department to include guidelines to facilitate the rapid assessment and initial resuscitation of the severely injured patient. Criteria addressing management during transport shall include continued assessment and management of airway, cervical spine, breathing, circulation, neurologic and secondary parameters, communication, and documentation;
   (d) Transport to determine the appropriate mode of transport and level of care required to transport, considering patient condition, requirement for trauma center resources, family requests, and capability of transferring entity;
   (e) Bypass procedures that define:
      (i) circumstances and criteria for bypass decisions;
      (ii) time and distance criteria; and
      (iii) mode of transport which bypasses closer facilities; and
   (f) Accident scene and inter-hospital diversion procedures that include delineation of specific factors such as hospital census or acuity, physician availability, staffing issues, disaster status, or transportation which would require routing of a patient to another hospital or Trauma Center;
(3) Transfer agreements (including those with other hospitals, as well as specialty care facilities such as burn, pediatrics, spinal cord, and rehabilitation) which shall outline mutual understandings between facilities to transfer/accept certain patients. These shall specify responsible parties, documentation requirements, and minimum care requirements; and
(4) A performance improvement plan that includes:
   (a) A regional trauma peer review committee of the RAC:
      (i) whose membership and responsibilities are defined in G.S. 131E-162; and
      (ii) that continuously evaluates the regional trauma system through structured review of process of care and outcomes; and
   (b) Utilization of patient care data.

History Note: *Authority G.S. 131E-162;*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

SECTION .1200 - TRAUMA SYSTEM DESIGN

10A NCAC 13P .1201 STATE TRAUMA SYSTEM PLAN
10A NCAC 13P .1202 REGIONAL TRAUMA SYSTEM PLAN
10A NCAC 13P .1203 REGIONAL TRAUMA SYSTEM POLICY DEVELOPMENT

History Note: Authority G.S. 131E-162;
Eff. August 1, 1998;
Repealed Eff. January 1, 2004.

SECTION .1300 - FORMS

10A NCAC 13P .1301 SOURCE OF FORMS AND DOCUMENTS

History Note: Authority G.S. 131E-162;
Eff. August 1, 1998;
Repealed Eff. January 1, 2004.

SECTION .1400 - RECOVERY AND REHABILITATION OF CHEMICALLY DEPENDENT EMS PERSONNEL

10A NCAC 13P .1401 CHEMICAL ADDICTION OR ABUSE RECOVERY PROGRAM REQUIREMENTS

(a) The OEMS shall provide a monitoring program for aiding in the recovery of EMS personnel subject to disciplinary action for being unable to perform as credentialed EMS personnel with reasonable skill and safety to patients and the public by reason of use of alcohol, drugs, chemicals, or any other type of material as set forth in Rule .1507 of this Subchapter.

(b) This program requires:

(1) an initial assessment by a healthcare professional specializing in chemical dependency approved by the program;

(2) a treatment plan developed by a healthcare professional specializing in chemical dependency for the individual using the findings of the initial assessment. The Department and individual will enter into a consent agreement based upon the treatment plan; and

(3) monitoring by OEMS program staff of the individual for compliance with the consent agreement entered into by the Department and the individual entering the program.

History Note: Authority G.S. 131E-159(f); 143-508(b); 143-508(d)(10);
Eff. October 1, 2010;
Readopted Eff. January 1, 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .1402 PROVISIONS FOR PARTICIPATION IN THE CHEMICAL ADDICTION OR ABUSE RECOVERY PROGRAM

The OEMS shall use the screening criteria set forth in this Section to determine whether an individual may enter the treatment program established by Rule .1401 of this Section. The individual may enter the program if the individual:

(1) acknowledges, in writing, the actions that violated the performance requirements found in this Subchapter;

(2) has not been charged or convicted at any time in his or her past, of diverting chemicals for the purpose of distribution, dealing, or selling illicit drugs;

(3) is not under current criminal investigation or subject to pending criminal charges by law enforcement;

(4) ceases in the direct delivery of any patient care and surrenders all EMS credentials until either the individual is eligible for issuance of an encumbered EMS credential pursuant to Rule .1403 of this Section, or has completed the treatment program established in Rule .1401 of this Section; and

(5) agrees to accept responsibility for all costs including assessment, treatment, monitoring, and body fluid screening.

History Note: Authority G.S. 131E-159(f); 143-508(b); 143-508(d)(10);
Eff. October 1, 2010;
Readopted Eff. January 1, 2017.

10A NCAC 13P .1403 CONDITIONS FOR RESTRICTED PRACTICE WITH LIMITED PRIVILEGES

(a) In order to assist in determining eligibility for an individual to return to restricted practice, completion of all requirements outlined in the individual's consent agreement with the Department as described in Rule .1401 of this Section shall be presented to the Chief of the OEMS.

(b) Individuals who have surrendered his or her EMS credential(s) as a condition of entry into the recovery program, as required in Rule .1402 of this Section, shall be reviewed by the OEMS Chief to determine if issuance of an encumbered EMS credential is warranted by the Department.

(c) In order to obtain an encumbered credential with limited privileges, an individual shall:

(1) be compliant for a minimum of 90 consecutive days with the treatment program described in Rule .1401 of this Section; and

(2) be recommended in writing for review by the individual's recovery healthcare professional overseeing the treatment plan developed as described in Rule .1401 of this Section.

(d) The individual shall agree to sign a consent agreement with the OEMS that details the practice restrictions and privilege limitations of the encumbered EMS credential, and that contains the consequences of failure to abide by the terms of this agreement.

(e) The individual shall be issued the encumbered credential by the OEMS within 10 business days following execution of the consent agreement described in Paragraph (d) of this Rule.

(f) The encumbered EMS credential shall be valid for a period not to exceed four years.

History Note: Authority G.S. 131E-159(f); 143-508(b); 143-508(d)(10);
Eff. October 1, 2010;
Readopted Eff. January 1, 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .1404 REINSTATEMENT OF AN UNENCUMBERED EMS CREDENTIAL

Reinstatement of an unencumbered EMS credential is dependent upon the individual completing all requirements of the consent agreement as set forth in Rule .1401 of this Section.

History Note: Authority G.S. 131E-159(f); 143-508(d)(10); 143-509(13);
Eff. October 1, 2010;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. July 1, 2021.

10A NCAC 13P .1405 FAILURE TO COMPLETE THE CHEMICAL ADDICTION OR ABUSE RECOVERY PROGRAM

Individuals who fail to complete the consent agreement established in Rule .1401 of this Section, upon review by the OEMS, are subject to revocation of their EMS credential.

History Note: Authority G.S. 131E-159(f); 143-508(b); 143-508(d)(10);
Eff. October 1, 2010;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. July 1, 2021; January 1, 2017.

SECTION .1500 - DENIAL, SUSPENSION, AMENDMENT, OR REVOCATION

10A NCAC 13P .1501 ENFORCEMENT DEFINITIONS

Notwithstanding Section .0100 of this Subchapter, for the purpose of this Section, the following definitions apply to Rules .1502, .1503, .1504, and .1506 for EMS Systems, Licensed EMS Providers, Specialty Care Transport Programs, and EMS Educational Institutions:

(1) "Contingencies" mean conditions placed on an initial or renewal designation, approval or license that, if unmet, can result in the loss or amendment of the designation, approval, or license.

(2) "Deficiency" means the failure to meet essential criteria for credentialing, approval, or licensing as specified in Sections .0200, .0300 or .0600 of this Subchapter that can serve as the basis for a focused review or denial of a designation, approval or license.

(3) "Essential Criteria" means those items listed in Sections .0200, .0300 or .0600 of this Subchapter that are the minimum requirements for the respective application for initial or renewal designation, approval, or licensing.

(4) "Focused Review" means an evaluation by the OEMS of a regulated entity's corrective actions to remove contingencies that are a result of deficiencies placed upon it following review of an application for renewal.

History Note: Authority G.S. 131E-155(13a); 143-508(b),(d)(1),(d)(4),(d)(13);
Eff. January 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

10A NCAC 13P .1502 LICENSED EMS PROVIDERS

(a) The OEMS shall deny an initial or renewal EMS Provider license for any of the following reasons:

(1) significant failure to comply, as defined in Rule .0102 of this Subchapter, with the applicable licensing requirements in Rule .0204 of this Subchapter;

(2) making false statements or representations to the OEMS or willfully concealing information in connection with an application for licensing;

(3) tampering with or falsifying any record used in the process of obtaining an initial license or in the renewal of a license; or

(4) disclosing information as defined in Rule .0223 of this Subchapter that is determined by OEMS staff, based upon review of documentation, to disqualify the applicant from licensing.

(b) The Department shall amend any EMS Provider license by amending it to reduce the license from a full license to a provisional license whenever the Department finds that:

(1) the licensee failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under that Article;

(2) there is a probability that the licensee can take corrective measures to resolve the issue of non-compliance with Rule .0204 of this Subchapter, and be able to remain in compliance within a reasonable length of time determined by OEMS staff on a case-by-case basis; and

(3) there is a probability, determined by OEMS staff using their professional judgment, based upon analysis of the licensee's ability to take corrective measures to resolve the issue of non-compliance with the licensure rules, that the licensee will be able thereafter to remain in compliance with the licensure rules.

(c) The Department shall give the licensee written notice of the amendment of the EMS Provider license. This notice shall be given personally or by certified mail and shall set forth:

(1) the duration of the provisional EMS Provider license;

(2) the factual allegations;

(3) the statutes or rules alleged to be violated; and

(4) notice of the EMS provider's right to a contested case hearing, as set forth in Rule .1509 of this Subchapter, on the amendment of the EMS Provider license.

(d) The provisional EMS Provider license is effective upon its receipt by the licensee and shall be posted in a location at the primary business location of the EMS Provider, accessible to public view, in lieu of the full license. Pursuant to G.S. 131E-155.1(d), the provisional license remains in effect until the Department:

(1) restores the licensee to full licensure status; or

(2) revokes the licensee's license.

(e) The Department shall revoke or suspend an EMS Provider license whenever the Department finds that the licensee:

(1) failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under that Article and it is not probable that the licensee can remedy the licensure deficiencies within 12 months or less;

(2) failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under that Article and, although the licensee may be able to remedy the deficiencies, it is not probable that the licensee will be able to remain in compliance with licensure rules;

(3) failed to comply with the provision of G.S. 131E, Article 7, and the rules adopted under that Article that endanger the health, safety, or welfare of the patients cared for or transported by the licensee;

(4) obtained or attempted to obtain an ambulance permit, EMS nontransporting vehicle permit, or EMS Provider license through fraud or misrepresentation;
(5) continues to repeat the same deficiencies placed on the licensee in previous compliance site visits;
(6) has recurring failure to provide emergency medical care within the defined EMS service area in a manner as determined by the EMS System;
(7) failed to disclose or report information in accordance with Rule .0223 of this Subchapter;
(8) was deemed by OEMS to place the public at risk because the owner, any officer, or agent was convicted in any court of a crime involving fiduciary misconduct or a conviction of a felony;
(9) altered, destroyed, attempted to destroy, withheld, or delayed release of evidence, records, or documents needed for a complaint investigation being conducted by the OEMS; or
(10) continues to operate within an EMS System after a Board of County Commissioners terminated its affiliation with the licensee, resulting in a violation of the licensing requirement set forth in Rule .0204 of this Subchapter.

(f) The Department shall give the EMS Provider written notice of revocation. This notice shall be given personally or by certified mail and shall set forth:
(1) the factual allegations;
(2) the statutes or rules alleged to be violated; and
(3) notice of the EMS Provider's right to a contested case hearing, as set forth in Rule .1509 of this Section, on the revocation of the EMS Provider's license.

(g) The issuance of a provisional EMS Provider license is not a procedural prerequisite to the revocation or suspension of a license pursuant to Paragraph (e) of this Rule.

History Note: Authority G.S. 131E-155.1(d); 143-508(d)(10);
Eff. January 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. July 1, 2018; January 1, 2017.

10A NCAC 13P .1503 SPECIALTY CARE TRANSPORT PROGRAMS

(a) The Department shall deny the initial or renewal approval, without first allowing a focused review, of a SCTP for any of the following reasons:
(1) failure to comply with the provisions of G.S.131E, Article 7 and the rules adopted under that Article;
(2) obtaining or attempting to obtain approval through fraud or misrepresentation;
(3) endangerment to the health, safety, or welfare of patients cared for by the SCTP; or
(4) repeated deficiencies placed on the program in previous site visits.

(b) When an SCTP is required to have a focused review, it must demonstrate compliance with the provisions of G.S. 131E, Article 7 and the rules adopted under that Article within 12 months or less.

(c) The Department shall revoke an SCTP approval at any time or deny a request for renewal of approval whenever the Department finds that the SCTP failed to comply with the provisions of G.S.131E, Article 7 and the rules adopted under that Article; and
(1) it is not probable that the SCTP can remedy the deficiencies within 12 months or less;
(2) although the SCTP may be able to remedy the deficiencies, it is not probable that the SCTP shall be able to remain in compliance with designation rules for the foreseeable future;
(3) the SCTP fails to meet the requirements of a focused review;
(4) endangerment to the health, safety, or welfare of patients cared for or transported by the SCTP;
(5) fails to provide SCTP services within the defined service area in a timely manner as determined by the Department;
(6) continues to operate within an EMS System after a Board of County Commissioners has terminated its affiliation with the SCTP; or
(7) alters, destroys or attempts to destroy evidence needed for a complaint investigation.

(d) The Department shall give the SCTP written notice of revocation. This notice shall be given personally or by certified mail and shall set forth:
(1) the factual allegations;
(2) the statutes or rules alleged to be violated; and
(3) notice of the program's right to a contested case hearing on the revocation of the approval.

(e) Focused review is not a procedural prerequisite to the revocation of an approval pursuant to Paragraph (c) of this Rule.

History Note: *Authority 143-508(d)(10), (d)(13);*
Eff. January 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

10A NCAC 13P .1504 TRAUMA CENTERS

(a) The Department shall deny the initial or renewal designation, without first allowing a focused review, of a trauma center for any of the following reasons:

(1) failure to comply with G.S. 131E-162 and the rules adopted under that Statute;
(2) obtaining or attempting to obtain a trauma center designation through fraud or misrepresentation;
(3) endangerment to the health, safety, or welfare of patients cared for in the hospital; or
(4) repeated deficiencies placed on the trauma center in previous site visits.

(b) When a trauma center is required to have a focused review, it must demonstrate compliance with the provisions of G.S. 131E-162 and the rules adopted under that Statute within 12 months or less.

(c) The Department shall revoke a trauma center designation at any time or deny a request for renewal of designation, whenever the Department finds that the trauma center has failed to comply with the provisions of G.S. 131E-162 and the rules adopted under that Statute; and

(1) it is not probable that the trauma center can remedy the deficiencies within 12 months or less;
(2) although the trauma center may be able to remedy the deficiencies it is not probable that the trauma center shall be able to remain in compliance with designation rules for the foreseeable future;
(3) the trauma center failed to meet the requirements of a focused review;
(4) failure to comply endangers the health, safety, or welfare of patients cared for in the trauma center; or
(5) the trauma center altered, destroyed or attempted to destroy evidence needed for a complaint investigation.

(d) The Department shall give the trauma center written notice of revocation. This notice shall be given personally or by certified mail and shall set forth:

(1) the factual allegations;
(2) the statutes or rules alleged to be violated; and
(3) notice of the hospital's right to a contested case hearing on the revocation of the designation.

(e) Focused review is not a procedural prerequisite to the revocation of a designation pursuant to Paragraph (c) of this Rule.

(f) A trauma center may voluntarily withdraw its designation for a maximum of one year by submitting a written request to the Department. This request shall include the reasons for withdrawal and a plan for resolution of the issues. To reactivate the designation, the facility shall provide to the Department written documentation of compliance. Voluntary withdrawal does not affect the original expiration date of the trauma center's designation.

(g) If the trauma center fails to resolve the issues which resulted in a voluntary withdrawal within one year, the Department shall revoke the trauma center designation.

(h) In the event of a revocation or voluntary withdrawal, the Department shall provide written notification to all hospitals and emergency medical services providers within the trauma center's defined trauma primary catchment area. The Department shall provide written notification to all hospitals and emergency medical services providers within the trauma center's defined trauma primary catchment area if, and when, the voluntary withdrawal reactivates to full designation.

History Note: *Authority G.S. 131E-162; 143-508(d)(10);*
Eff. January 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

10A NCAC 13P .1505 EMS EDUCATIONAL INSTITUTIONS

(a) For the purpose of this Rule, "focused review" means an evaluation by the OEMS of an educational institution's corrective actions to remove contingencies that are a result of deficiencies identified in the initial or renewal application process.
(b) The Department shall deny the initial or renewal designation, without first allowing a focused review, of an EMS Educational Institution. An Educational Institution denied initial designation shall not be eligible to reapply to the OEMS for two years. Reasons for denial are:

(1) significant failure to comply with the provisions of Sections .0500 and .0600 of this Subchapter; or
(2) attempting to obtain an EMS Educational Institution designation through fraud or misrepresentation.

(c) When an EMS Educational Institution is required to have a focused review, it shall demonstrate compliance with the provisions of Sections .0500 and .0600 of this Subchapter within six months or less.
(d) The Department shall amend, suspend, or revoke an EMS Educational Institution designation at any time whenever the Department finds that the EMS Educational Institution has significant failure to comply, as defined in Rule .0102 of this Subchapter, with the provisions of Section .0600 of this Subchapter, and:

(1) it is not probable that the EMS Educational Institution can remedy the deficiencies within six months or less as determined by OEMS staff based upon analysis of the educational institution's ability to take corrective measures to resolve the issue of non-compliance with Section .0600 of this Subchapter;
(2) although the EMS Educational Institution may be able to remedy the deficiencies, it is not probable that the EMS Educational Institution shall be able to remain in compliance with credentialing rules;
(3) failure to produce records upon request as required in Rule .0601 of this Subchapter;
(4) the EMS Educational Institution failed to meet the requirements of a focused review within six months, as set forth in Paragraph (c) of this Rule;
(5) the failure to comply endangered the health, safety, or welfare of patients cared for as part of an EMS educational program as determined by OEMS staff in their professional judgment based upon a complaint investigation, in consultation with the Department and Department of Justice, to verify the results of the investigations are sufficient to initiate enforcement action pursuant to G.S. 150B; or
(6) the EMS Educational Institution altered, destroyed, or attempted to destroy evidence needed for a complaint investigation.

(e) The Department shall give the EMS Educational Institution written notice of action taken on the Institution designation. This notice shall be given personally or by certified mail and shall set forth:

(1) the factual allegations;
(2) the statutes or rules alleged to be violated; and
(3) notice of the EMS Educational Institution's right to a contested case hearing, set forth in Rule .1509 of this Section, on the revocation of the designation.

(f) Focused review is not a procedural prerequisite to the revocation of a designation as set forth in Rule .1509 of this Section.
(g) If determined by the educational institution that suspending its approval to offer EMS educational programs is necessary, the EMS Educational Institution may voluntarily surrender its credential without explanation by submitting a written request to the OEMS stating its intention. The voluntary surrender shall not affect the original expiration date of the EMS Educational Institution's designation. To reactivate the designation:

(1) the institution shall provide OEMS written documentation requesting reactivation; and
(2) the OEMS shall verify the educational institution is compliant with all credentialing requirements set forth in Section .0600 of this Subchapter prior to reactivation of the designation by the OEMS.

(h) If the institution fails to resolve the issues that resulted in a voluntary surrender, the Department shall revoke the EMS Educational Institution designation.
(i) In the event of a revocation or voluntary surrender, the Department shall provide written notification to all EMS Systems within the EMS Educational Institution's defined service area. The Department shall provide written notification to all EMS Systems within the EMS Educational Institution's defined service area when the voluntary surrender reactivates to full credential.
(j) When an accredited EMS Educational Institution as defined in Rule .0605 of this Subchapter has administrative action taken against its accreditation, the OEMS shall determine if the cause of action is sufficient for revocation of the EMS Educational Institution designation or imposing a focused review pursuant to Paragraphs (b) and (c) of this Rule is warranted.

History Note: Authority G.S. 143-508(d)(4); 143-508(d)(10);
Eff. January 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. April 1, 2024; July 1, 2021; July 1, 2018; January 1, 2017.

10A NCAC 13P .1506 EMS VEHICLE PERMITS

(a) The Department shall deny, suspend, or revoke the permit of an ambulance or EMS nontransporting vehicle if the EMS Provider:

(1) failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under that Article;
(2) obtained or attempted to obtain a permit through fraud or misrepresentation;
(3) has continued deficiencies identified as repeated from previous compliance site visits;
(4) failed to provide emergency medical care within the defined EMS service area in a timely manner as determined by the EMS System;
(5) continued to operate the ambulance or nontransporting vehicle in a county after written notification by a Board of Commissioners to cease operations in that county;
(6) altered, destroyed or attempted to destroy evidence needed for a complaint investigation; or
(7) does not possess a valid EMS Provider License.

(b) In lieu of suspension or revocation, the Department shall issue a temporary permit for an ambulance or EMS nontransporting vehicle whenever the Department finds that:

(1) the EMS Provider to which that vehicle is assigned has failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under that Article;
(2) there is a reasonable probability that the EMS Provider can remedy the permit deficiencies within a length of time determined by the Department; and
(3) there is a reasonable probability that the EMS Provider will be willing and able to remain in compliance with the rules regarding vehicle permits for the foreseeable future.

(c) The Department shall give the EMS Provider written notice of the temporary permit. This notice shall be given personally or by certified mail and shall set forth:

(1) the duration of the temporary permit not to exceed 60 days;
(2) a copy of the vehicle inspection form;
(3) the statutes or rules alleged to be violated; and
(4) notice of the EMS Provider's right to a contested case hearing on the temporary permit.

(d) The temporary permit is effective immediately upon its receipt by the EMS Provider and remains in effect until the earlier of the expiration date of the permit or until the Department:

(1) restores the vehicle to full permitted status; or
(2) suspends or revokes the vehicle permit.

History Note: Authority G.S. 131E-156(c),(d); 131E-157(c);
Eff. January 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

10A NCAC 13P .1507 EMS PERSONNEL CREDENTIALS

(a) Any EMS credential that has been forfeited under G.S. 15A-1331.1 may not be reinstated until the person has complied with the court's requirements, has petitioned the Department for reinstatement, has completed the disciplinary process, and has received Department reinstatement approval.

(b) The Department shall amend, deny, suspend, or revoke the credentials of EMS personnel for any of the following:

(1) significant failure to comply with the applicable performance and credentialing requirements as found in this Subchapter;
(2) making false statements or representations to the Department, or concealing information in connection with an application for credentials;
(3) making false statements or representations, concealing information, or failing to respond to inquiries from the Department during a complaint investigation;

(4) tampering with, or falsifying any record used in the process of obtaining an initial EMS credential, or in the renewal of an EMS credential;
(5) in any manner or using any medium, engaging in the stealing, manipulating, copying, reproducing, or reconstructing of any written EMS credentialing examination questions, or scenarios;
(6) cheating, or assisting others to cheat while preparing to take, or when taking a written EMS credentialing examination;
(7) altering an EMS credential, using an EMS credential that has been altered, or permitting or allowing another person to use his or her EMS credential for the purpose of alteration. "Altering" includes changing the name, expiration date, or any other information appearing on the EMS credential;
(8) unprofessional conduct, including a significant failure to comply with the rules relating to the function of credentialed EMS personnel contained in this Subchapter, or the performance of or attempt to perform a procedure that is detrimental to the health and safety of any person, or that is beyond the scope of practice of credentialed EMS personnel or EMS instructors;
(9) being unable to perform as credentialed EMS personnel with reasonable skill and safety to patients and the public by reason of illness that will compromise skill and safety, use of alcohol, drugs, chemicals, or any other type of material, or by reason of any physical impairment;
(10) conviction in any court of a crime involving moral turpitude, a conviction of a felony, a conviction requiring registering on a sex offender registry, or conviction of a crime involving the scope of practice of credentialed EMS personnel;
(11) by theft or false representations, obtaining or attempting to obtain, money or anything of value from a patient, EMS Agency, or educational institution;
(12) adjudication of mental incompetence;
(13) lack of competence to practice with a reasonable degree of skill and safety for patients, including a failure to perform a prescribed procedure, failure to perform a prescribed procedure competently, or performance of a procedure that is not within the scope of practice of credentialed EMS personnel or EMS instructors;
(14) performing as a credentialed EMS personnel in any EMS System in which the individual is not affiliated and authorized to function;
(15) performing or authorizing the performance of procedures, or administration of medications detrimental to a student or individual;
(16) delay or failure to respond when on-duty and dispatched to a call for EMS assistance;
(17) testing positive, whether for-cause or at random, through urine, blood, or breath sampling, for any substance, legal or illegal, that is likely to impair the physical or psychological ability of the credentialed EMS personnel to perform all required or expected functions while on duty;
(18) failure to comply with G.S. 143-518 regarding the use or disclosure of records or data associated with EMS Systems, Specialty Care Transport Programs, Alternative Practice Settings, or patients;
(19) refusing to consent to any criminal history check required by G.S. 131E-159;
(20) abandoning or neglecting a patient who is in need of care, without making arrangements for the continuation of such care;
(21) falsifying a patient's record or any controlled substance records;
(22) harassing, abusing, or intimidating a patient, EMS personnel, other allied healthcare personnel, student, educational institution staff, members of the public, or OEMS staff, either physically, verbally, or in writing;
(23) engaging in any activities of a sexual nature with a patient, including kissing, fondling, or touching while responsible for the care of that individual;
(24) any criminal arrests that involve charges that have been determined by the Department to indicate a necessity to seek action in order to further protect the public pending adjudication by a court;
(25) altering, destroying, or attempting to destroy evidence needed for a complaint investigation being conducted by the OEMS;
(26) significant failure to comply with a condition to the issuance of an encumbered EMS credential with limited and restricted practices for persons in the chemical addiction or abuse treatment program;
(27) unauthorized possession of lethal or non-lethal weapons, chemical irritants to include mace, pepper (oleoresin capsicum) spray and tear gas, or explosives while in the performance of providing emergency medical services;

(28) significant failure to comply to provide EMS care records to the licensed EMS provider for submission to the OEMS as required by Rule .0204 of this Subchapter;
(29) continuing to provide EMS care after local suspension of practice privileges by the local EMS System, Medical Director, or Alternative Practice Setting;
(30) representing or allowing others to represent that the credentialed EMS personnel has a credential that the credentialed EMS personnel does not in fact have;
(31) diversion of any medication requiring medical oversight for credentialed EMS personnel;
(32) filing a knowingly false complaint against an individual, EMS Agency, or educational institution; or
(33) failure to comply with educational requirements defined in Sections .0500 and .0600 of this Subchapter.

(c) Pursuant to the provisions of G.S. 131E-159(h), the OEMS shall not issue an EMS credential for any person listed on the North Carolina Department of Public Safety, Sex Offender and Public Protection Registry, or who was convicted of an offense that would have required registration if committed at a time when the registration would have been required by law.

(d) Pursuant to the provisions of G.S. 50-13.12, upon notification by the court, the OEMS shall revoke an individual's EMS credential until the Department has been notified by the court that evidence has been obtained of compliance with a child support order. The provisions of G.S. 50-13.12 supersede the requirements of Paragraph (f) of this Rule.

(e) When a person who is credentialed to practice as an EMS professional is also credentialed in another jurisdiction and the other jurisdiction takes disciplinary action against the person, the Department shall summarily impose the same or lesser disciplinary action upon receipt of the other jurisdiction's action. The EMS professional may request a hearing before the EMS Disciplinary Committee. At the hearing the issues shall be limited to:

(1) whether the person against whom action was taken by the other jurisdiction and the Department are the same person;
(2) whether the conduct found by the other jurisdiction also violates the rules of the N.C. Medical Care Commission; and
(3) whether the sanction imposed by the other jurisdiction is lawful under North Carolina law.

(f) The OEMS shall provide written notification of the amendment, denial, suspension, or revocation. This notice shall be given personally or by certified mail, and shall set forth:

(1) the factual allegations;
(2) the statutes or rules alleged to have been violated; and
(3) notice of the individual's right to a contested hearing, set forth in Rule .1509 of this Section, on the revocation of the credential.

(g) The OEMS shall provide written notification to the EMS professional within five business days after information has been entered into the National Practitioner Data Bank and the Healthcare Integrity and Protection Integrity Data Bank.

(h) The EMS System Administrator, Primary Agency Contact, Medical Director, Educational Institution Program Coordinator, or Medical Advisor shall notify the OEMS of any violation listed in Paragraph (b) of this Rule within 30 days of discovery of the violation or upon completion of the internal agency or EMS system investigation.

History Note: *Authority G.S. 131E-159; 143-508(d)(10); 143-519;*
Eff. January 1, 2013;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

10A NCAC 13P .1508 SUMMARY SUSPENSION

In accordance with G.S. 150B-3(c) an EMS Provider License, EMS Vehicle Permit, or EMS credential may be summarily suspended if the public health, safety, or welfare requires emergency action. This determination is delegated to the Chief of the OEMS. For EMS credentials, this determination shall be made following review by the EMS Disciplinary Committee pursuant to G.S. 131E-159(f). Such a finding shall be incorporated with the order of the Department and the order is effective on the date specified in the order or on service of the certified copy of the order at the last known address of the affected party, whichever is later, and continues to be effective during the proceedings. Failure to receive the order because of refusal of service or unknown address does not invalidate the order.

History Note: Authority G.S. 131E-159(f); 150B-3(c);
Eff. January 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

10A NCAC 13P .1509 PROCEDURES FOR DENIAL, SUSPENSION, AMENDMENT, OR REVOCATION

The procedures for contested cases in G.S. 150B, Article 3, apply to the denial, suspension, amendment or revocation of credentials, licenses, permits, approvals, or designations.

History Note: Authority G.S. 143-508(d)(10);
Eff. January 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016.

10A NCAC 13P .1510 PROCEDURES FOR THE VOLUNTARY SURRENDER OR MODIFICATION OF THE LEVEL OF AN EMS CREDENTIAL

(a) An individual who holds a valid North Carolina EMS credential may request to voluntarily surrender the credential to the OEMS by:

(1) providing written notice stating the individual's desire to surrender the credential and explaining the circumstances surrounding the request; and
(2) returning the pocket credential and wall certificate to the OEMS upon notification the request has been approved.

(b) An individual who holds a valid North Carolina EMS credential may request to voluntarily modify the current credentialing level from a higher level to a lower level by the OEMS by:

(1) providing written notice stating the individual's desire to lower his or her current level and explaining the circumstances surrounding the request and stating the desired level of credentialing; and
(2) returning the pocket credential and wall certificate to the OEMS upon notification the request has been approved.

(c) The OEMS shall provide a written response to the individual within 10 business days following receipt of the request either approving or denying the request. This response shall describe the reason(s) for approval or denial.

(d) If the individual seeks to restore the credential to the previous status, the individual shall:

(1) wait a minimum of six months from the date the action was taken;
(2) provide written notice stating the individual's desire to restore the previous credential;
(3) provide evidence of continuing education at a minimum of two hours per month at the level of the EMS credential being sought; and
(4) undergo a criminal history background check.

(e) If the OEMS denies the individual's request for restoration of the EMS credential, the OEMS shall provide in writing the reason(s) for denial and inform the individual of the procedures for contested case hearing as set forth in Rule .1509 of this Section.

History Note: Authority G.S. 131E-159(g); 143-508(d)(3); 143-508(d)(10);
Eff. January 1, 2017.

10A NCAC 13P .1511 PROCEDURES FOR QUALIFYING FOR AN EMS CREDENTIAL FOLLOWING ENFORCEMENT ACTION

(a) Any individual who has been subject to suspension, revocation, or amendment of an EMS credential shall submit in writing to the OEMS a request for review to determine eligibility for credentialing.

(b) Factors the Department shall consider when determining eligibility shall include:

(1) the reason for administrative action, including:
 (A) criminal history;
 (B) patient care;
 (C) substance abuse; and
 (D) failure to meet credentialing requirements;
(2) the length of time since the administrative action was taken; and

(3) any mitigating or aggravating factors relevant to obtaining a valid EMS credential.

(c) In order to be considered for eligibility, the individual shall:

(1) wait a minimum of 36 months following administrative action before seeking review; and

(2) undergo a criminal history background check. If the individual has been charged or convicted of a misdemeanor or felony in this or any other state or country within the previous 36 months, the 36 month waiting period shall begin from the date of the latest charge or conviction.

(d) If determined to be eligible, the Department shall grant authorization for the individual to begin the process for EMS credentialing as set forth in Rule .0502 of this Subchapter.

(e) Prior to enrollment in an EMS educational program, the individual shall disclose the prior administrative action taken against the individual's credential in writing to the EMS Educational Institution.

(f) An individual who has undergone administrative action against his or her EMS credential is not eligible for legal recognition as defined in G.S. 131E-159(d) or issuance of a temporary EMS credential as defined in G.S. 131E-159(e).

(g) For a period of 10 years following restoration of the EMS credential, the individual shall disclose the prior administrative action taken against his or her credential to every EMS System, Medical Director, EMS Provider, and EMS Educational Institution where he or she is affiliated and provide a letter to the OEMS from each verifying disclosure.

(h) If the Department determines the individual is ineligible for EMS credentialing pursuant to this Rule, the Department shall provide in writing the reason(s) for denial and inform him or her of the procedures for contested case hearing as set forth in Rule .1509 of this Section.

History Note: *Authority G.S. 131E-159(g); 143-508(d)(3); 143-508(d)(10);*
Eff. January 1, 2017;
Amended Eff. July 1, 2021.

SUBCHAPTER 13Q – EMS FORMULA GRANTS

SECTION .0100 - FORMULA FOR DISTRIBUTION OF EMERGENCY MEDICAL SERVICES (EMS) SYSTEM DEVELOPMENT GRANT FUNDS

10A NCAC 13Q .0101 FORMULA FOR ALLOCATION OF STATE FUNDS
10A NCAC 13Q .0102 FORMULA FOR ALLOCATION OF FEDERAL FUNDS
10A NCAC 13Q .0103 IMPLEMENTATION OF FUNDING FORMULA

History Note: Authority G.S. 143-508;
Eff. July 1, 1994;
Repealed Eff. January 1, 2009.

SUBCHAPTER 13R – MINIMUM STANDARDS FOR MOBILE INTENSIVE CARE UNITS

SECTION .0100 - DEFINITIONS

10A NCAC 13R .0101 MOBILE INTENSIVE CARE UNIT I

History Note: Authority G.S. 131E-157(a); 131E-158(b); 131E-159(b);
Eff. November 26, 1976;
Readopted Eff. December 19, 1977;
Amended Eff. June 1, 1994; September 1, 1986; October 28, 1981;
Repealed Eff. January 1, 2009.

10A NCAC 13R .0102 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13R .0103 MOBILE INTENSIVE CARE UNIT III

History Note: *Authority G.S. 131E-157(a); 131E-158(b); 131E-159(b);*
Eff. November 26, 1976;
Readopted Eff. December 19, 1977;
Amended Eff. June 1, 1994; September 1, 1986; October 28, 1981;
Repealed Eff. January 1, 2009.

10A NCAC 13R .0104 MOBILE INTENSIVE CARE UNIT IV

History Note: *Authority G.S. 131E-157(a); 131E-158(b); 131E-159(b);*
Eff. March 1, 1989;
Amended Eff. June 1, 1994;
Repealed Eff. January 1, 2009.

10A NCAC 13R .0105 ADVANCED LIFE SUPPORT NONTRANSPORTING UNIT

History Note: *Authority G.S. 131E-157(a);*
Eff. November 26, 1976;
Readopted Eff. December 19, 1977;
Amended Eff. March 1, 1989; September 1, 1986;
Repealed Eff. January 1, 2009.

SECTION .0200 - EQUIPMENT

10A NCAC 13R .0201 GENERAL
10A NCAC 13R .0202 MOBILE INTENSIVE CARE UNIT (MICU) I

History Note: *Authority G.S. 131E-157(a);*
Eff. November 26, 1976;
Readopted Eff. December 19, 1977;
Amended Eff. November 1, 1995; August 1, 1994; November 1, 1989, March 1, 1989; September 1, 1986;
Repealed Eff. January 1, 2009.

10A NCAC 13R .0203 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13R .0204 MOBILE INTENSIVE CARE UNIT III

History Note: *Authority G.S. 131E-157(a);*
Eff. November 26, 1976;
Readopted Eff. December 19, 1977;
Amended Eff. November 1, 1995; August 1, 1994; November 1, 1989; March 1, 1989;
Repealed Eff. January 1, 2009.

10A NCAC 13R .0205 MOBILE INTENSIVE CARE UNIT IV

History Note: *Authority G.S. 131E-157(a);*
Eff. March 1, 1989;
Amended Eff. November 1, 1995; August 1, 1994;
Repealed Eff. January 1, 2009.

10A NCAC 13R .0206 ADVANCED LIFE SUPPORT NONTRANSPORTING UNIT

History Note: *Authority G.S. 131E-157(a);*
Eff. September 1, 1986;
Amended Eff. November 1, 1995; March 1, 1989;
Repealed Eff. January 1, 2009.

SECTION .0300 – COMMUNICATION

10A NCAC 13R .0301 TWO-WAY RADIO

History Note: *Authority G.S. 131E-157(a);*
Eff. November 26, 1976;
Readopted Eff. December 19, 1977;
Amended Eff. March 1, 1989; September 1, 1986;
Repealed Eff. January 1, 2009.

SUBCHAPTER 13S — LICENSURE OF SUITABLE FACILITIES FOR THE PERFORMANCE OF SURGICAL ABORTIONS

SECTION .0100 — LICENSURE PROCEDURE

10A NCAC 13S .0101 DEFINITIONS

The following definitions will apply throughout this Subchapter:

(1) "Abortion" means the termination of a pregnancy as defined in G.S 90-21.81(1c).

(2) "Clinic" means a freestanding facility neither physically attached nor operated by a licensed hospital for the performance of abortions completed during the first 12 weeks of pregnancy.

(3) "Division" means the Division of Health Service Regulation of the North Carolina Department of Health and Human Services.

(4) "Emergency Case" is defined as a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs.

(5) "Gestational age" means the length of pregnancy as indicated by the date of the first day of the last normal monthly menstrual period, if known, or as determined by ultrasound.

(6) "Governing authority" means the individual, agency, group, or corporation appointed, elected or otherwise designated, in which the ultimate responsibility and authority for the conduct of the abortion clinic is vested pursuant to Rule .0318 of this Subchapter.

(7) "Health Care Practitioner" means a physician, nurse practitioner, or physician's assistant licensed and authorized to practice in the state of North Carolina.

(8) "Health Screening" means an evaluation of an employee or contractual employee, including at a minimum tuberculosis testing or screening, to identify underlying health conditions that may affect the person's ability to work in the clinic.

(9) "New clinic" means one that is not certified as an abortion clinic by the Division as of July 1, 2023, and has not been certified or licensed within the previous six months of the application for licensure.

(10) "Pre-procedure activities" are activities performed prior to the procedure to ensure that the patient is stable, and that the procedure can be safely performed.

(11) "Post-procedure" activities are activities performed after the procedure to ensure that the patient is stable for discharge.

(12) "Registered Nurse" means a person who holds a valid license issued by the North Carolina Board of Nursing to practice professional nursing in accordance with the Nursing Practice Act, G.S. 90, Article 9A.

(13) "Safe and adequate care" means care that meets the clinical needs of the patient while preventing harm from occurring to the patient.

History Note: *Authority G.S. 131E-153.5; 143B-165;*
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;

Temporary Adoption Eff. February 8, 2024;
Eff. October 1, 2024.

10A NCAC 13S .0104 PLANS AND SPECIFICATIONS

(a) Prior to issuance of a license pursuant to 10A NCAC 14E .0107, an applicant for a new clinic shall submit one copy of construction documents and specifications to the Division for review and approval consistent with Section .0200 of this Subchapter.
(b) Any license holder or prospective applicant desiring to make alterations or additions to a clinic or to construct a new clinic, before commencing such alteration, addition or new construction shall submit construction documents and specifications to the Division for review and approval with respect to compliance with this Subchapter.
(c) Approval of construction documents and specifications shall expire one year after the date of approval unless a building permit for the construction has been obtained prior to the expiration date of the approval of construction documents and specifications.

History Note: Authority G.S. 131E-153.5; 143B-165;
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Eff. October 1, 2024.

10A NCAC 13S .0106 APPLICATION

History Note: Authority G.S. 131E-153; 131E-153.2; 131E-153.5; 143B-165;
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Emergency Rule Expired Eff. December 18, 2023.

10A NCAC 13S .0107 ISSUANCE OF LICENSE

History Note: Authority G.S. 131E-153; 131E-153.2; 131E-153.5; 143B-165;
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Emergency Rule Expired Eff. December 18, 2023.

10A NCAC 13S .0109 RENEWAL

History Note: Authority G.S. 131E-153; 131E-153.2; 131E-153.5; 143B-165;
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Emergency Rule Expired Eff. December 18, 2023.

10A NCAC 13S .0111 INSPECTIONS

History Note: Authority G.S. 131E-153.2; 131E-153.5; 131E-153.6; 143B-165;
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Temporary Adoption Expired Eff. November 26, 2024.

10A NCAC 13S .0112 ALTERATIONS

History Note: *Authority G.S. 131E-153.5; 143B-165;*
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Temporary Adoption Expired Eff. November 26, 2024.

10A NCAC 13S .0114 APPROVAL

History Note: *Authority G.S. 131E-153.5; 143B-165;*
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Temporary Adoption Expired Eff. November 26, 2024.

SECTION .0200 — MINIMUM STANDARDS FOR CONSTRUCTION AND EQUIPMENT

10A NCAC 13S .0201 BUILDING CODE REQUIREMENTS

(a) All clinics shall be classified for occupancy as Group B pursuant to the North Carolina Building Code.
(b) All new and existing clinics shall meet the requirements of the North Carolina State Building Codes, as determined by the applicability provisions of the North Carolina Building Code or the North Carolina Existing Building Code.
(c) The North Carolina Building Codes are hereby incorporated by reference including subsequent amendments and editions. Copies of the North Carolina State Building Codes can be obtained from the International Code Council online at https://shop.iccsafe.org/catalogsearch/result/?cat=1010&q=+North+Carolina+Building+code for a cost of eight hundred fifty eight dollars ($858.00) or accessed electronically free of charge at https://www.ncosfm.gov/codes/codes-current-and-past.

History Note: *Authority G.S. 131E-153.5; 143B-165;*
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Eff. October 1, 2024.

10A NCAC 13S .0202 SANITATION

History Note: *Authority G.S. 131E-153.5; 143B-165;*
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Temporary Adoption Expired Eff. November 26, 2024.

10A NCAC 13S .0207 AREA REQUIREMENTS

The following areas shall comply with Rule .0212 of this Section, and are minimum requirements for clinics that are licensed by the Division to perform abortions:

(1) reception and waiting room;
(2) designated area or areas for pre-procedure and post-procedure activities;
(3) procedure room;
(4) a clean area for self-contained secure medication storage complying with security requirements of State and federal laws;
(5) area compliant with Clinical Laboratory Improvement Amendments (CLIA) requirements, 42 CFR Part 493, including subsequent amendments and additions, which are hereby incorporated by

reference, available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-493 at no cost, in which laboratory testing can be performed;

(6) separate areas for storage and handling of clean and soiled materials;

(7) patient toilet;

(8) personnel toilet facilities;

(9) janitor's closets;

(10) space and equipment for assembling, sterilizing and storing medical and surgical supplies;

(11) storage space for medical records of all media types used by the facility; and

(12) space for charting, communications, counseling, business functions, and other administrative activities.

History Note: *Authority G.S. 131E-153.5; 143B-165;*
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Eff. October 1, 2024.

10A NCAC 13S .0209 ELEVATOR

History Note: *Authority G.S. 131E-153.5; 143B-165;*
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Temporary Adoption Expired Eff. November 26, 2024.

10A NCAC 13S .0210 CORRIDORS

History Note: *Authority 131E-153.5; 143B-165;*
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Temporary Adoption Expired Eff. November 26, 2024.

10A NCAC 13S .0211 DOORS

History Note: *Authority G.S. 131E-153.5; 143B-165;*
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Temporary Adoption Expired Eff. November 26, 2024.

10A NCAC 13S .0212 ELEMENTS AND EQUIPMENT

The physical plant shall provide equipment to carry out the functions of the clinic with the following requirements:

(1) Mechanical requirements.

(a) All fans serving exhaust systems shall be located at the discharge end of the system.

(b) The ventilation system shall be designed and balanced to provide the pressure relationships detailed in Sub-Item (f) of this Rule.

(c) All ventilation or air conditioning systems shall have a minimum of one filter bed with a minimum filter efficiency of a MERV 8.

(d) Ventilation systems serving the procedure rooms shall not be tied in with toilets, soiled holding, or janitors' closets if the air is to be recirculated in any manner.

(e) Air handling duct systems shall not have duct linings.

(f) The following general air pressure relationships to adjacent areas and ventilation rates shall apply:

Area	Pressure Relationship	Minimum Total Air Changes/Hour
Toilets	N	4
Janitor's closet	N	6
Soiled holding	N	6
Clean holding	NR	2

(N = negative pressure NR = No Requirement)

(2) Plumbing And Other Piping Systems.

(a) Piped-in medical gas and vacuum systems, if installed, shall meet the requirements of NFPA-99, category 2 system, which is hereby incorporated by reference including subsequent amendments and editions. Copies of NFPA-99 may be purchased from the National Fire Protection Association online at https://www.nfpa.org/product/nfpa-99-code/p0099code at a cost of one hundred forty-nine dollars ($149.00).

(b) Lavatories and sinks for use by medical personnel shall have the water supply spout mounted so that its discharge point is a minimum distance of ten (10) inches above the bottom of the basin with mixing type fixture valves that can be operated without the use of the hands.

(c) Hot water distribution systems shall provide hot water at hand washing facilities at a minimum temperature of 100 degrees F. and a maximum temperature of 116 degrees F.

(3) Electrical Requirements.

(a) The facility's paths of egress to the outside shall have at a minimum, listed battery backup lighting units of one and one-half hour capability that will automatically provide at least one foot candle of illumination at the floor in the event needed for a utility or local lighting circuit failure.

(b) Electrically operated medical equipment necessary for the safety of the patient shall have, at a minimum, battery backup.

(4) Buildings systems and medical equipment shall have preventative maintenance conducted as recommended by the equipment manufacturers' or installers' literature to assure operation in compliance with manufacturer's instructions.

History Note: *Authority G.S. 131E-153.5; 143B-165;*
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Eff. October 1, 2024.

10A NCAC 13S .0315 HOUSEKEEPING

History Note: *Authority G.S. 131E-153.5; 143B-165;*
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Temporary Adoption Expired Eff. November 26 2024.

10A NCAC 13S .0318 GOVERNING AUTHORITY

(a) The governing authority, as defined in Rule .0101(6) of this Subchapter, shall appoint a chief executive officer or a designee of the clinic to represent the governing authority and shall define his or her authority and duties in writing. This person shall be responsible for the management of the clinic, implementation of the policies of the governing authority, and authorized and empowered to carry out the provisions of these Rules.

(b) The chief executive officer or designee shall designate, in writing, a person to act on his or her behalf during his or her absence. In the absence of the chief executive officer or designee, the person on the grounds of the clinic who

is designated by the chief executive officer or designee to be in charge of the clinic shall have access to all areas in the clinic related to patient care and to the operation of the physical plant.
(c) When there is a planned change in ownership or in the chief executive officer, the governing authority of the clinic shall notify the Division in writing of the change.
(d) The clinic's governing authority shall adopt operating policies and procedures that shall:

(1) specify the individual to whom responsibility for operation and maintenance of the clinic is delegated and methods established by the governing authority for holding such individuals responsible;
(2) provide for at least annual meetings of the governing authority, for which minutes shall be maintained; and
(3) maintain a policies and procedures manual designed to ensure safe and adequate care for the patients which shall be reviewed, and revised when necessary, at least annually, and shall include provisions for administration and use of the clinic, compliance with statutes and rules applicable to clinics including Subchapters 13S and 14E of Title 10A, compliance with a nationally standard recognized standard of care for infection control, personnel quality assurance, procurement of outside services and consultations, patient care policies, grievance policies, and services offered.

(e) When the clinic contracts with outside vendors to provide services such as laundry or therapy services, the governing authority shall be responsible to assure the supplier meets the same local and State standards the clinic would have to meet if it were providing those services itself using its own staff.
(f) The governing authority shall provide for the selection and appointment of the professional staff and the granting of clinical privileges and shall be responsible for the professional conduct of these persons.
(g) The governing authority shall be responsible for ensuring the availability of supporting personnel to meet patient needs and to provide safe and adequate treatment.

History Note: Authority G.S. 131E-153.5; 143B-165;
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Eff. October 1, 2024.

10A NCAC 13S .0319 POLICIES AND PROCEDURES AND ADMINISTRATIVE RECORDS

(a) The following documents and references shall be on file in the administrative office of the clinic:

(1) documents evidencing control and ownerships, such as deeds, leases, or incorporation or partnership papers;
(2) policies and procedures of the governing authority, as required by Rule .0318 of this Section;
(3) minutes of the governing authority meetings;
(4) minutes of the clinic's professional and administrative staff meetings;
(5) a current copy of the rules of this Subchapter;
(6) reports of inspections, reviews, and corrective actions taken related to licensure; and
(7) contracts and agreements related to care and services provided by the clinic as a party.

(b) All operating licenses, permits, and certificates shall be displayed on the licensed premises.
(c) The governing authority shall prepare a manual of clinic policies and procedures for use by employees, medical staff, and physicians to assist them in understanding their responsibilities within the organizational framework of the clinic. These shall include:

(1) patient selection and exclusion criteria;
(2) clinical discharge criteria;
(3) emergency protocols as required by Rule .0326;
(4) policy and procedure for validating the full and true name of the patient;
(5) policy and procedure for abortion procedures performed at the clinic;
(6) policy and procedure for the provision of patient privacy in the recovery area of the clinic;
(7) protocol for determining gestational age as defined in Rule .0101(5) of this Subchapter; and
(8) protocol for referral of patients declined services by the clinic.

History Note: Authority G.S. 131E-153.5; 143B-165;

Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Eff. October 1, 2024.

10A NCAC 13S .0320 ADMISSION AND DISCHARGE

(a) There shall be on the premises throughout all hours of operation an employee authorized to receive patients and make administrative decisions regarding patients. Administrative decisions include all of the decisions related to a patient's care and services, such as admissions, billing, and services provided.
(b) All patients shall be admitted only under the care of a physician who is currently licensed to practice medicine in North Carolina.
(c) Any patient not discharged within 12 hours following the abortion procedure shall be transferred to a hospital licensed pursuant to Chapter 131E, Article 5 of the General Statutes.
(d) Following admission and prior to obtaining the consent for the procedure, representatives of the clinic's management shall provide to each patient the following information:

(1) a fee schedule and any extra charges routinely applied;
(2) the name of the attending physician or physicians and hospital admitting privileges. In the absence of admitting privileges a statement documenting that the attending physician or physicians does not have admitting privileges shall be included;
(3) instructions for post-procedure problems and questions as outlined in Rule .0329(d) of this Section;
(4) grievance procedures a patient may follow if dissatisfied with the care and services rendered pursuant to the grievance policy as outlined in Rule .0318(d)(3) of this Section; and
(5) the telephone number for Complaint Intake of the Division.

History Note: Authority G.S. 131E-153.5; 143B-165;
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Eff. October 1, 2024.

10A NCAC 13S .0321 MEDICAL RECORDS

(a) The clinic shall maintain a complete and permanent record for all patients including:

(1) the date and time of admission and discharge;
(2) the patient's full and true name;
(3) the patient's address;
(4) the patient's date of birth;
(5) the patient's emergency contact information;
(6) the patient's diagnoses;
(7) the fetus's gestational age;
(8) the patient's condition on admission and discharge;
(9) a voluntarily-signed consent for each procedure and signature of the physician performing the procedure witnessed by a family member, other patient representative, or facility staff member;
(10) a copy of the signed 72 hour consent and physician declaration as defined in G.S. 90-21.82;
(11) the patient's history and physical examination including identification of pre-existing or current illnesses, drug sensitivities or other idiosyncrasies that may impact the procedure or anesthetic to be administered; and
(12) documentation that indicates all items listed in Rule .0320(d) of this Section were provided to the patient.

(b) The clinic shall record and authenticate by signature, date, and time all other pertinent information such as pre- and post-procedure instructions, laboratory reports, drugs administered, report of abortion procedure, and follow-up instruction, including family planning advice.
(c) If Rh is negative, the clinic shall explain the significance to the patient and shall record the explanation. A written record of the patient's decision shall be a permanent part of her medical record.

(d) An ultrasound examination shall be performed and the results, including gestational age, placed in the patient's medical record for any patient who is scheduled for an abortion procedure.
(e) The clinic shall maintain a daily procedure log of all patients receiving abortion services. This log shall contain at least the following:

(1) the patient name;
(2) the estimated gestational age;
(3) the type of procedure;
(4) the name of the physician:
(5) the name of the Registered Nurse on duty; and
(6) the date and time of procedure.

(f) Medical records shall be the property of the clinic and shall be preserved or retained in the State of North Carolina for a period of not less than 10 years from the date of the most recent discharge, unless the client is a minor, in which case the record must be retained until three years after the client's 18th birthday, regardless of change of clinic ownership or administration. Such medical records shall be made available to the Division upon request and shall not be removed from the premises where they are retained except by subpoena or court order.
(g) The clinic shall have a written plan for destruction of medical records to identify information to be retained and the manner of destruction to ensure confidentiality of all material.
(h) Should a clinic cease operation, the clinic shall arrange for preservation of records for at least 10 years. The clinic shall send written notification to the Division of these arrangements.

History Note: *Authority G.S. 131E-153.5; 143B-165;*
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Eff. October 1, 2024.

10A NCAC 13S .0322 PERSONNEL RECORDS

(a) Personnel Records:

(1) A record of each employee shall be maintained that includes the following:
  (A) the employee's identification;
  (B) the application for employment or resume that includes education, training, experience and references; and
  (C) a copy of a valid license (if required).
(2) Personnel records shall be confidential.
(3) Representatives of the Division conducting an inspection of the clinic shall have the right to inspect personnel records.

(b) Job Descriptions:

(1) The clinic shall have a written description that describes the duties of every position.
(2) Each job description shall include position title, authority, specific responsibilities, and minimum qualifications. Qualifications shall include education, training, experience, special abilities, and valid license or certification required.
(3) The clinic shall review annually and, if needed, update all job descriptions. The clinic shall provide the updated job description to each employee or contractual employee assigned to the position.

(c) All persons having direct responsibility for patient care shall be at least 18 years of age.
(d) The clinic shall provide an orientation program to familiarize each new employee or contractual employee with the clinic, its policies, and the employee's job responsibilities.
(e) The governing authority shall be responsible for implementing health standards for employees, as well as contractual employees, which are consistent with recognized professional practices for the prevention and transmission of communicable diseases.
(f) Employee and contractual employee records for health screening as defined in Rule .0101(8) of this Subchapter, education, training, and verification of professional certification shall be available for review by the Division.

History Note: *Authority G.S. 131E-153.5; 143B-165;*

Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Eff. October 1, 2024.

10A NCAC 13S .0323 CLINIC STAFFING

(a) The clinic shall have an organized clinical staff under the supervision of a nursing supervisor who is currently licensed as a Registered Nurse and who has responsibility for all nursing services.
(b) The nursing supervisor shall report to the chief executive officer or designee and shall be responsible for:
(1) provision of nursing services to patients; and
(2) developing a nursing policy and procedure manual and written job descriptions for nursing personnel.
(c) The clinic shall have the number of licensed and ancillary nursing personnel on duty to assure that staffing levels meet the total nursing needs of patients based on the number of patients in the clinic and their individual nursing care needs.
(d) There shall be at least one Registered Nurse who is currently licensed to practice professional nursing in North Carolina, or other health care practitioner practicing within the scope of their license or certification who is basic life support (BLS) certified and authorized by state laws to administer medications as required for analgesia, nausea, vomiting, or other indications on duty in the clinic at all times patients are in the procedure rooms and recovery area.

History Note: Authority G.S. 131E-153.5; 143B-165;
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Eff. October 1, 2024.

10A NCAC 13S .0324 QUALITY ASSURANCE

(a) The governing authority shall establish a quality assurance program for the purpose of providing standards of care for the clinic. The program shall include the establishment of a committee that shall evaluate compliance with clinic procedures and policies.
(b) The committee shall determine corrective action, if necessary to achieve and maintain compliance with clinic procedures and policies.
(c) The committee shall consist of one physician who is not an owner, the chief executive officer or designee, and other health practitioners.
(d) The frequency of meetings and details of data collection shall be defined by the governing authority.

History Note: Authority G.S. 131E-153.5; 143B-165;
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Eff. October 1, 2024.

10A NCAC 13S .0325 LABORATORY SERVICES

(a) Each clinic shall have the capability to provide or obtain laboratory tests required in connection with the procedure to be performed, and will perform laboratory tests appropriate to their Clinical Laboratory Improvement Amendments (CLIA) certification.
(b) The governing authority shall establish written policies regarding which surgical specimens require examination by a pathologist.
(c) Each patient shall have laboratory testing as determined to be clinically necessary by the physician, or as required by law. A record of the results of any tests performed will be included in the patient's medical record.
(d) The clinic shall maintain a manual in a location accessible by employees, that meets requirements for the level of clinic's CLIA certification. This includes the procedures, instructions, and manufacturer's instructions for each test procedure performed including:

(1) sources of reagents, and quality control procedures; and
(2) information concerning the basis for the listed "normal" ranges.

History Note: *Authority G.S. 131E-153.5; 143B-165;*
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Eff. October 1, 2024.

10A NCAC 13S .0326 EMERGENCY BACK-UP SERVICES

(a) Each clinic shall have a written plan for the transfer of emergency cases from the clinic to the closest hospital when hospitalization becomes necessary.
(b) The clinic shall have written protocols, personnel, and equipment to handle medical emergencies as defined above which may arise in connection with services provided by the clinic.
(c) All clinics shall have written emergency case instructions for clinic staff to carry out in the event of an emergency. All clinic personnel shall have access to and be capable of carrying out the clinic's written emergency case instructions:
(1) Instructions shall be followed in the event of an emergency, any unexpected anesthetic, medical or procedural complications, or other conditions making transfer to an emergency department and/or hospitalization of a patient necessary.
(2) The instructions shall include arrangements for immediate contact of emergency medical services when indicated and when advanced cardiac life support is needed.
(3) When emergency medical services are not indicated, the instructions shall include procedures for timely escort of the patient to the hospital or to an appropriate licensed health care professional.
(d) The clinic shall provide intervention for emergency cases. These provisions shall include:
(1) basic cardio-pulmonary life support;
(2) emergency instructions for:
(A) administration of intravenous fluids;
(B) establishing and maintaining airway support;
(C) oxygen administration;
(D) utilizing a bag-valve-mask resuscitator with oxygen reservoir; and
(E) utilizing an automated external defibrillator.
(3) emergency lighting available in the procedure room as set forth in Rule .0212 of this Subchapter; and
(4) ultrasound equipment.

History Note: *Authority G.S. 131E-153.5; 143B-165;*
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Eff. October 1, 2024.

10A NCAC 13S .0327 OUTPATIENT PROCEDURAL SERVICES

(a) The clinic shall establish procedures for infection control and universal precautions, including cleaning of all patient care areas including procedure rooms.
(b) Tissue Examination:
(1) The physician performing the abortion is responsible for examination of all products of conception (P.O.C.) prior to patient discharge. Such examination shall note specifically the presence or absence of chorionic villi and fetal parts, or the amniotic sac. The results of the examination shall be recorded in the patient's medical record.
(2) If adequate tissue is not obtained based on the gestational age, the physician performing the procedure shall evaluate for ectopic pregnancy, or an incomplete procedure.
(3) The clinic shall establish procedures for obtaining, identifying, storing, and transporting specimens.

History Note: Authority G.S. 131E-153.5; 143B-165;
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Eff. October 1, 2024.

10A NCAC 13S .0328 MEDICATIONS AND SEDATION

(a) No medication or treatment shall be given except on written order of a physician.
(b) Medications, including injections shall be administered by a physician, Registered Nurse, and other health care practitioners practicing within the scope of their license or certification authorized by state laws to administer medications. All medications shall be recorded in the patient's permanent record.
(c) The sedation shall be administered only under the direct supervision of a licensed physician. Direct supervision means the physician must be present in the clinic and immediately available to furnish assistance and direction throughout the administration of the sedation. It does not mean the physician must be present in the room when the sedation is administered.

History Note: Authority G.S. 131E-153.5; 143B-165;
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Eff. October 1, 2024.

10A NCAC 13S .0329 POST PROCEDURAL CARE

(a) A patient whose pregnancy is terminated shall be observed in the clinic to ensure that no post procedural complications are present. Thereafter, patients may be discharged according to a physician's order and the clinic's protocols.
(b) Any patient having a complication known or suspected to have occurred during or after the performance of the abortion shall be transferred to a hospital for evaluation or admission.
(c) The following criteria shall be documented prior to discharge:

(1) the patient shall be able to move independently with a stable blood pressure and pulse; and
(2) bleeding and pain are assessed to be stable and not a concern for discharge.

(d) Written instructions shall be issued to all patients in accordance with the orders of the physician in charge of the abortion procedure and shall include the following:

(1) symptoms and complications to be looked for; and
(2) a dedicated telephone number to be used by the patients should any complication occur or question arise. This number shall be answered by a person 24 hours a day, seven days a week.

(e) The clinic shall have a defined protocol for triaging post-operative calls and complications. This protocol shall establish a pathway for physician contact to ensure ongoing care of complications that the clinic's physician is incapable of managing.

History Note: Authority G.S. 131E-153.5; 143B-165;
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Eff. October 1, 2024.

10A NCAC 13S .0330 CLEANING OF MATERIALS AND EQUIPMENT

(a) All supplies and equipment used in patient care shall be cleaned or sterilized between use for different patients.
(b) Methods of cleaning, handling, and storing all supplies and equipment shall be such as to prevent the transmission of infection through their use as determined by the clinic through their governing authority.

History Note: Authority G.S. 131E-153.5; 143B-165;

Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Eff. October 1, 2024.

10A NCAC 13S .0331 FOOD SERVICE

Nourishments, such as crackers and soft drinks, shall be available and offered to all patients.

History Note: Authority G.S. 131E-153.2; 131E-153.5; 143B-165;
Codifier determined that findings of need did not meet criteria for emergency rule on October 30, 2023;
Emergency Rule Eff. November 14, 2023;
Temporary Adoption Eff. February 8, 2024;
Eff. October 1, 2024.