SUBCHAPTER 13D – RULES FOR THE LICENSING OF NURSING HOMES

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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;
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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.