

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
NORTH CAROLINA MEDICAL CARE COMMISSION

PLANNING MEETING

DUKE MEDICAL CENTER
MEDICAL BOARD CENTER ROOM # 1170 B
40 DUKE MEDICINE CIRCLE
DURHAM, NORTH CAROLINA 27710

WEDNESDAY, MAY 9, 2018
3:00 P.M.

- I. Meeting Opens and Comments.....Dr. John Fagg
- II. Temporary Solutions Information Session.....Danny Stutzman
- III. OLD BUSINESS
- A. Rules for Adoption (Rules, Fiscal Note and Comments)
(See Exhibits C-C/3)
- Emergency Services and Trauma Rules (Nadine Pfeiffer & Tom Mitchell)
Amendments to update standards and incorporate changes in practice settings:
- 10A NCAC 13P .0102, .0201, .0222, .0301, .0505, .0506, .0904, .1502, and .1505
- IV. NEW BUSINESS
- A. Rules for Initiating Rulemaking Approval (Rules & Fiscal Note)
(See Exhibits D-D/3)
- Hearings: Transfers and Discharges Rules (Nadine Pfeiffer & Beverly Speroff)
Readoption of three rules following Periodic Review:
- 10A NCAC 14A .0301, .0302, .0303
- B. Periodic Review of Existing Rules (HB 74) (Initial Category Determination)
(See Exhibits E-E/2)
- Licensing of Family Care Homes Rules (Nadine Pfeiffer, Megan Lamphere & Steven Lewis)
Initial category determination for:
- 10A NCAC 13G
- C. Adoption of FGI Rules (Update) (Steven Lewis)
- V. NEW PROJECT PROPOSAL
- A. NC Office of Emergency Services.....Geary Knapp & Tom Mitchell

Resolution: The Commission grants preliminary approval to a project for the North Carolina Office of Emergency Medical Services (NCOEMS) to provide funds in the amount of **\$556,893** for upgrades to the North Carolina Mobile Disaster Hospital. The upgrades are necessary to maintain operational capabilities and ensure readiness for deployment of the Mobile Disaster Hospital. The specific use of the funds is as follows:

BUDGET ESTIMATES		
<i>Activity</i>	<i>Units/Cost</i>	<i>Total Cost</i>
<i>Patient Care</i>		
Patient Headwalls for Expandable Shelters	20/\$1,500.00 per	\$30,000.00
Upgrade X-ray Processors	2/\$27,450.00 per	\$54,900.00
Hospital Beds	20/\$5,482.40 per	\$109,648.00
Life Safety Systems for Patient Care Areas	1/\$12,500.00 per	\$12,500.00
Vacuum and Medical Air Pump Assembly	2/\$116,000.00 per	\$232,000.00
<i>Structural Upgrades</i>		
Hard Sided Connectors for Patient Care Area Structure	12/\$6,600.00 per	\$79,200.00
Expandable Shelters Interior Paint	10/\$2,000.00 per	\$20,000.00
Expandable Shelters Replacement Lights	35/\$47.00 per	\$1,645.00
Machined Brackets for Lights	70/\$12.00 per	\$840.00
Hydraulic Pump System for Lifting Jacks	1/\$2,500.00 per	\$2,500.00
Hydraulic Lifting Jacks for Expandable Shelters	4/\$600.00 per	\$2,400.00
Scissor Jacks for Leveling Expandable Shelters	30/\$25.00 per	\$750.00
Custom Plates and Pins for Scissor Jacks	30/\$20.00 per	\$600.00
Shelter Recondition for Vacuum Pump/Medical Air Holding	1/\$10,000.00 per	\$10,000.00
TOTAL		\$556,893.00

Tentative approval is given with the understanding that NCOEMS accepts the following conditions:

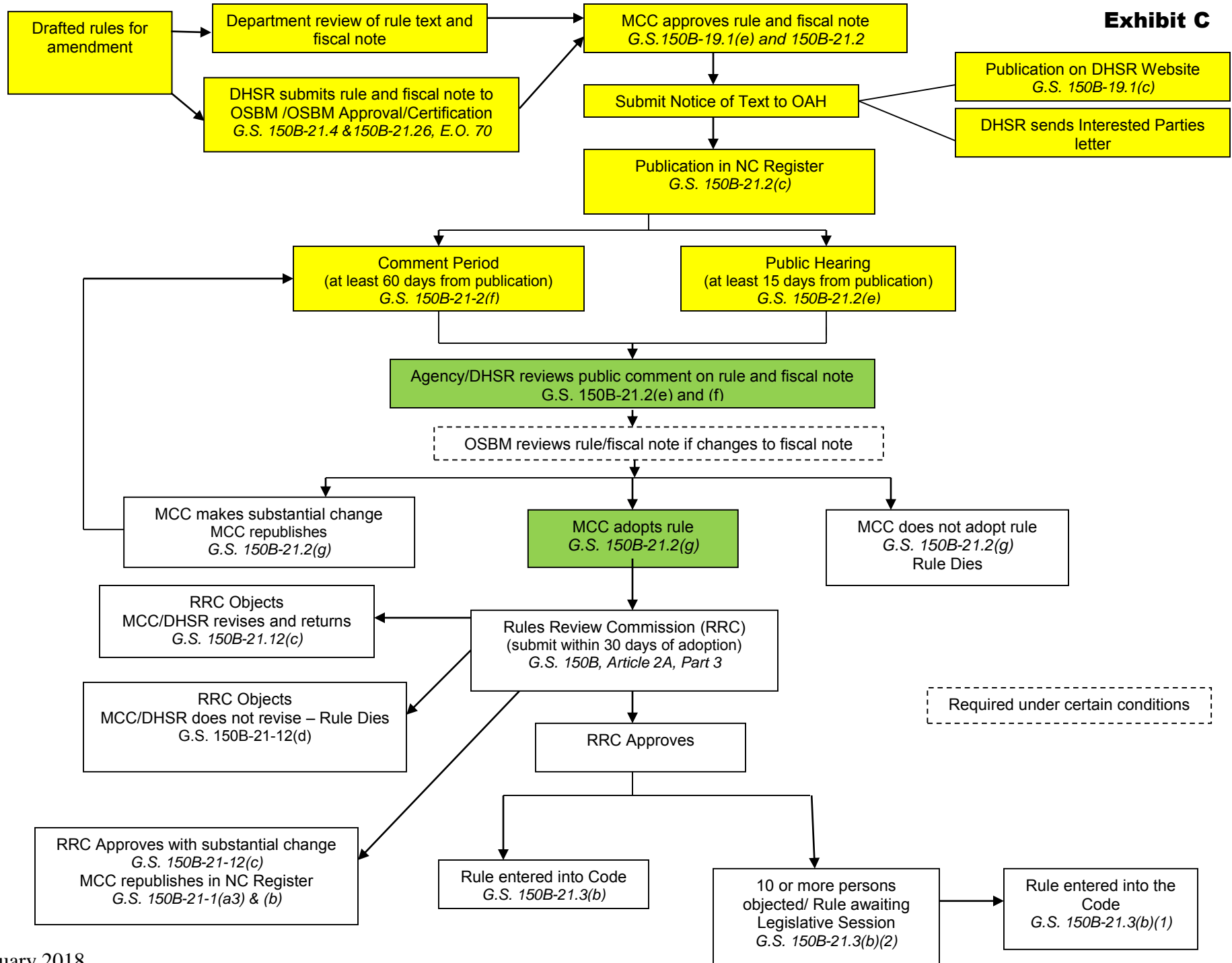
1. The project will continue to be developed pursuant to the applicable Medical Care Commission guidelines.
2. The project will continue to be developed pursuant to all applicable North Carolina purchasing guidelines.
3. The project must, in all respects, meet requirements of G.S. § 131A (Health Care Facilities Finance Act).
4. The Executive Committee of the Commission is delegated the authority to approve the final expenditure of funds for this project and may approve the expenditure of such greater amount as shall be necessary to finance the project; provided, however, that the amount set forth above shall not be increased by more than ten percent (10%).

VI. Mission Health Update.....Geary Knapp

VII. Meeting Adjournment – The Agenda is to be referred to the Thursday, May 10, 2018 meeting without any action being taken.

Permanent Rulemaking Process for: Emergency Medical Services and Trauma Rules 10A NCAC 13P (Amendments)

Exhibit C



1 10A NCAC 13P .0102 is amended with changes as published in 32:11 NCR 1026-1036 as follows:

2

3 **10A NCAC 13P .0102 DEFINITIONS**

4 In addition to the definitions in G.S. 131E-155, the following definitions apply throughout this Subchapter:

5 (1) "Affiliated EMS Provider" means the firm, corporation, agency, organization, or association
6 identified ~~to~~ with a specific county EMS system as a condition for EMS Provider Licensing as
7 required by Rule ~~.0204(b)(4)~~ .0204 of this Subchapter.

8 (2) "Affiliated Hospital" means a non-trauma center hospital that is owned by the Trauma Center or
9 there is a contract or other agreement to allow for the acceptance or transfer of the Trauma Center's
10 patient population to the non-trauma center hospital.

11 (3) "Affiliate" or "Affiliation" means a reciprocal agreement and association that includes active
12 participation, collaboration, and involvement in a process or system between two or more parties.

13 (4) "Alternative Practice Setting" means ~~a clinical environment~~ a practice setting that utilizes
14 credentialed EMS personnel that may not be affiliated with or under the oversight of ~~the~~ an EMS
15 System or EMS System Medical Director.

16 (5) "Air Medical Ambulance" means an aircraft configured and medically equipped to transport patients
17 by air. The patient care compartment of air medical ambulances shall be staffed by medical crew
18 members approved for the mission by the Medical Director.

19 (6) "Air Medical Program" means a SCTP or EMS System utilizing rotary-wing or fixed-wing aircraft
20 configured and operated to transport patients.

21 (7) "Assistant Medical Director" means a physician, EMS-PA, or EMS-NP who assists the Medical
22 Director with the medical aspects of the management of ~~an EMS System or SCTP~~, a practice setting
23 utilizing credentialed EMS personnel or medical crew members.

24 (8) "Bypass" means a decision made by the patient care technician to transport a patient from the scene
25 of an accident or medical emergency past a receiving facility for the purposes of accessing a facility
26 with a higher level of care, or a hospital of its own volition reroutes a patient from the scene of an
27 accident or medical emergency or referring hospital to a facility with a higher level of care.

28 (9) "Community Paramedicine" means an EMS System utilizing credentialed personnel who have
29 received additional training as determined by the EMS system Medical Director to provide
30 knowledge and skills for the community needs beyond the 911 emergency response and transport
31 operating guidelines defined in the EMS system plan.

32 ~~(9)~~ (10) "Contingencies" mean conditions placed on a designation that, if unmet, may result in the loss or
33 amendment of a designation.

34 ~~(10)~~ (11) "Convalescent Ambulance" means an ambulance used on a scheduled basis solely to transport
35 patients having a known non-emergency medical condition. Convalescent ambulances shall not be
36 used in place of any other category of ambulance defined in this Subchapter.

1 ~~(11)~~ (12) "Deficiency" means the failure to meet essential criteria for a designation that can serve as the basis
2 for a focused review or denial of a designation.

3 ~~(12)~~ (13) "Department" means the North Carolina Department of Health and Human Services.

4 ~~(13)~~ (14) "Diversion" means the hospital is unable to accept a patient due to a lack of staffing or resources.

5 ~~(14)~~ (15) "Educational Medical Advisor" means the physician responsible for overseeing the medical aspects
6 of approved EMS educational programs.

7 ~~(15)~~ (16) "EMS Care" means all services provided within each EMS System by its affiliated EMS agencies
8 and personnel that relate to the dispatch, response, treatment, and disposition of any patient.

9 ~~(16)~~ (17) "EMS Educational Institution" means any agency credentialed by the OEMS to offer EMS
10 educational programs.

11 ~~(17)~~ (18) "EMS Non-Transporting Vehicle" means a motor vehicle operated by a licensed EMS provider
12 dedicated and equipped to move medical equipment and EMS personnel functioning within the
13 scope of practice of an AEMT or Paramedic to the scene of a request for assistance. EMS
14 nontransporting vehicles shall not be used for the transportation of patients on the streets, highways,
15 waterways, or airways of the state.

16 ~~(18)~~ (19) "EMS Peer Review Committee" means a committee as defined in G.S. 131E-155(6b).

17 ~~(19)~~ (20) "EMS Performance Improvement Self-Tracking and Assessment of Targeted Statistics" means one
18 or more reports generated from the State EMS data system analyzing the EMS service delivery,
19 personnel performance, and patient care provided by an EMS system and its associated EMS
20 agencies and personnel. Each EMS Performance Improvement Self-Tracking and Assessment of
21 Targeted Statistics focuses on a topic of care such as trauma, cardiac arrest, EMS response times,
22 stroke, STEMI (heart attack), and pediatric care.

23 ~~(20)~~ (21) "EMS Provider" means those entities defined in G.S. 131E-155(13a) that hold a current license
24 issued by the Department pursuant to G.S. 131E-155.1.

25 ~~(21)~~ (22) "EMS System" means a coordinated arrangement of local resources under the authority of the
26 county government (including all agencies, personnel, equipment, and facilities) organized to
27 respond to medical emergencies and integrated with other health care providers and networks
28 including public health, community health monitoring activities, and special needs populations.

29 ~~(22)~~ (23) "Essential Criteria" means those items that are the requirements for the respective level of trauma
30 center designation (I, II, or III), as set forth in Rule .0901 of this Subchapter.

31 ~~(23)~~ (24) "Focused Review" means an evaluation by the OEMS of corrective actions to remove contingencies
32 that are a result of deficiencies following a site visit.

33 ~~(24)~~ (25) "Ground Ambulance" means an ambulance used to transport patients with traumatic or medical
34 conditions or patients for whom the need for specialty ~~care care, or emergency emergency,~~ or non-
35 emergency medical care is anticipated either at the patient location or during transport.

- 1 ~~(25)~~ (26) "Hospital" means a licensed facility as defined in G.S. ~~131E-176~~, 131E-176 or an acute care in-
- 2 patient diagnostic and treatment facility located within the State of North Carolina that is owned and
- 3 operated by an agency of the United States government.
- 4 ~~(26)~~ (27) "Immediately Available" means the physical presence of the health professional or the hospital
- 5 resource within the trauma center to evaluate and care for the trauma patient.
- 6 ~~(27)~~ (28) "Inclusive Trauma System" means an organized, multi-disciplinary, evidence-based approach to
- 7 provide quality care and to improve measurable outcomes for all defined injured patients. EMS,
- 8 hospitals, other health systems, and clinicians shall participate in a structured manner through
- 9 leadership, advocacy, injury prevention, education, clinical care, performance improvement, and
- 10 research resulting in integrated trauma care.
- 11 ~~(28)~~ (29) "Infectious Disease Control Policy" means a written policy describing how the EMS system will
- 12 protect and prevent its patients and EMS professionals from exposure and illness associated with
- 13 contagions and infectious disease.
- 14 ~~(29)~~ (30) "Lead RAC Agency" means the agency (comprised of one or more Level I or II trauma centers)
- 15 that provides staff support and serves as the coordinating entity for trauma planning.
- 16 ~~(30)~~ (31) "Level I Trauma Center" means a hospital that has the capability of providing guidance, research,
- 17 and total care for every aspect of injury from prevention to rehabilitation.
- 18 ~~(31)~~ (32) "Level II Trauma Center" means a hospital that provides trauma care regardless of the severity of
- 19 the ~~injury~~ injury, but may lack the comprehensive care as a Level I trauma ~~center~~ center, and does
- 20 not have trauma research as a primary objective.
- 21 ~~(32)~~ (33) "Level III Trauma Center" means a hospital that provides assessment, resuscitation, emergency
- 22 operations, and stabilization, and arranges for hospital transfer as needed to a Level I or II trauma
- 23 center.
- 24 ~~(33)~~ (34) "Licensed Health Care Facility" means any health care facility or hospital licensed by the
- 25 Department of Health and Human Services, Division of Health Service Regulation.
- 26 ~~(34)~~ (35) "Medical Crew Member" means EMS personnel or other health care professionals who are licensed
- 27 or registered in North Carolina and are affiliated with a SCTP.
- 28 ~~(35)~~ (36) "Medical Director" means the physician responsible for the medical aspects of the management
- 29 of ~~an EMS System, Alternative Practice Setting, SCTP, a practice setting utilizing credentialed EMS~~
- 30 personnel or medical crew members, or a Trauma Center.
- 31 ~~(36)~~ (37) "Medical Oversight" means the responsibility for the management and accountability of the medical
- 32 care aspects of ~~an EMS System, Alternative Practice Setting, or SCTP~~, a practice setting utilizing
- 33 credentialed EMS personnel or medical crew members. Medical Oversight includes physician
- 34 direction of the initial education and continuing education of EMS personnel or medical crew
- 35 members; development and monitoring of both operational and treatment protocols; evaluation of
- 36 the medical care rendered by EMS personnel or medical crew members; participation in system or

1 program evaluation; and directing, by two-way voice communications, the medical care rendered
2 by the EMS personnel or medical crew members.

3 ~~(37)~~ (38) "Mobile Integrated Healthcare" means utilizing credentialed personnel who have received
4 additional training as determined by the Alternative Practice Setting medical director to provide
5 knowledge and skills for the healthcare provider program needs.

6 ~~(37)~~ (39) "Off-line Medical Control" means medical supervision provided through the EMS System Medical
7 Director or SCTP Medical Director who is responsible for the day-to-day medical care provided by
8 EMS personnel. This includes EMS personnel education, protocol development, quality
9 management, peer review activities, and EMS administrative responsibilities related to assurance of
10 quality medical care.

11 ~~(38)~~ (40) "Office of Emergency Medical Services" means a section of the Division of Health Service
12 Regulation of the North Carolina Department of Health and Human Services located at 1201
13 Umstead Drive, Raleigh, North Carolina 27603.

14 ~~(39)~~ (41) "On-line Medical Control" means the medical supervision or oversight provided to EMS personnel
15 through direct communication in-person, via radio, cellular phone, or other communication device
16 during the time the patient is under the care of an EMS professional.

17 ~~(40)~~ (42) "Operational Protocols" means the administrative policies and procedures of an EMS System or
18 that provide guidance for the day-to-day operation of the system.

19 ~~(41)~~ (43) "Participating Hospital" means a hospital that supplements care within a larger trauma system by
20 the initial evaluation and assessment of injured patients for transfer to a designated trauma center if
21 needed.

22 ~~(42)~~ (44) "Physician" means a medical or osteopathic doctor licensed by the North Carolina Medical Board
23 to practice medicine in the state of North Carolina.

24 ~~(43)~~ (45) "Regional Advisory Committee" means a committee comprised of a lead RAC agency and a group
25 representing trauma care providers and the community, for the purpose of regional ~~trauma~~ planning,
26 establishing, and maintaining a coordinated trauma system.

27 ~~(44)~~ (46) "Request for Proposal" means a State document that must be completed by each hospital seeking
28 initial or renewal trauma center designation.

29 ~~(45)~~ (47) "Significant Failure to Comply" means a degree of non-compliance determined by the OEMS
30 during compliance monitoring to exceed the ability of the local EMS System to correct, warranting
31 enforcement action pursuant to Section .1500 of this Subchapter.

32 ~~(46)~~ (48) "State Medical Asset and Resource Tracking Tool" means the Internet web-based program used by
33 the OEMS both ~~daily~~ in its daily operations and during times of disaster to identify, ~~record~~ record,
34 and monitor EMS, hospital, health ~~care~~ care, and sheltering resources statewide, including facilities,
35 personnel, vehicles, equipment, and pharmaceutical and supply caches.

36 ~~(47)~~ (49) "Specialty Care Transport Program" means a program designed and operated for the transportation
37 of a patient by ground or air requiring specialized interventions, ~~monitoring~~ monitoring, and staffing

1 by a paramedic who has received additional training as determined by the program Medical Director
2 beyond the minimum training prescribed by the OEMS, or by one or more other healthcare
3 professional(s) qualified for the provision of specialized care based on the patient's condition.

4 ~~(48)~~ (50) "Specialty Care Transport Program Continuing Education Coordinator" means a Level I EMS
5 Instructor within a SCTP who is responsible for the coordination of EMS continuing education
6 programs for EMS personnel within the program.

7 ~~(49)~~ (51) "Stretcher" means any wheeled or portable device capable of transporting a person in a recumbent
8 position and may only be used in an ambulance vehicle permitted by the Department.

9 ~~(50)~~ (52) "Stroke" means an acute cerebrovascular hemorrhage or occlusion resulting in a neurologic deficit.

10 ~~(51)~~ (53) "System Continuing Education Coordinator" means the Level I EMS Instructor designated by the
11 local EMS System who is responsible for the coordination of EMS continuing education programs.

12 ~~(52)~~ (54) "System Data" means all information required for daily electronic submission to the OEMS by all
13 EMS Systems using the EMS data set, data dictionary, and file format as specified in "North
14 Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection,"
15 incorporated herein by reference including subsequent amendments and editions. This document is
16 available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no
17 cost and online at www.ncems.org at no cost.

18 ~~(53)~~ (55) "Trauma Center" means a hospital designated by the State of North Carolina and distinguished by
19 its ability to manage, on a 24-hour basis, the severely injured patient or those at risk for severe
20 injury.

21 ~~(54)~~ (56) "Trauma Center Criteria" means essential criteria to define Level I, II, or III trauma centers.

22 ~~(55)~~ (57) "Trauma Center Designation" means a process of approval in which a hospital voluntarily seeks to
23 have its trauma care capabilities and performance evaluated by experienced on-site reviewers.

24 ~~(56)~~ (58) "Trauma Diversion" means a trauma center of its own volition declines to accept an acutely injured
25 patient due to a lack of staffing or resources.

26 ~~(57)~~ (59) "Trauma Guidelines" mean standards for practice in a variety of situations within the trauma system.

27 ~~(58)~~ (60) "Trauma Minimum Data Set" means the basic data required of all hospitals for submission to the
28 Trauma Registry.

29 ~~(59)~~ (61) "Trauma Patient" means any patient with an ICD-CM discharge diagnosis as defined in the "North
30 Carolina Trauma Registry Data Dictionary," incorporated herein by reference in accordance with
31 G.S.150B-21.6, including subsequent amendments and editions. This document is available from
32 the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost and online
33 at <https://www.ncdhhs.gov/dhsr/EMS/trauma/traumaregistry.html> at no cost.

34 ~~(60)~~ (62) "Trauma Program" means an administrative entity that includes the trauma service and coordinates
35 other trauma-related activities. It shall also include the trauma Medical Director, trauma program
36 manager/trauma coordinator, and trauma registrar. This program's reporting structure shall give it

1 the ability to interact with at least equal authority with other departments in the hospital providing
2 patient care.

3 ~~(61)~~ (63) "Trauma Registry" means a disease-specific data collection composed of a file of uniform data
4 elements that describe the injury event, demographics, pre-hospital information, diagnosis, care,
5 outcomes, and costs of treatment for injured patients collected and electronically submitted as
6 defined by the OEMS. The elements of the Trauma Registry can be accessed at
7 <https://www.ncdhhs.gov/dhsr/EMS/trauma/traumaregistry.html> at no cost.

8 ~~(62)~~ (64) "Treatment Protocols" means a document approved by the Medical Directors of the local EMS
9 System, Specialty Care Transport Program, Alternative Practice Setting, or Trauma Center and the
10 OEMS specifying the diagnostic procedures, treatment procedures, medication administration, and
11 patient-care-related policies that shall be completed by EMS personnel or medical crew members
12 based upon the assessment of a patient.

13 ~~(63)~~ (65) "Triage" means the assessment and categorization of a patient to determine the level of EMS and
14 healthcare facility based care required.

15 ~~(64)~~ (66) "Water Ambulance" means a watercraft specifically configured and medically equipped to transport
16 patients.

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18 *History Note:* Authority G.S. 131E-155(6b); 131E-162; 143-508(b), 143-508(d)(1); 143-508(d)(2); 143-
19 508(d)(3); 143-508(d)(4); 143-508(d)(5); 143-508(d)(6); 143-508(d)(7); 143-508(d)(8); 143-
20 508(d)(13); 143-518(a)(5);
21 *Temporary Adoption Eff. January 1, 2002;*
22 *Eff. April 1, 2003;*
23 *Amended Eff. March 3, 2009 pursuant to E.O. 9, Beverly Perdue, March 3, 2009;*
24 *Pursuant to G.S. 150B-21.3(c), a bill was not ratified by the General Assembly to disapprove this*
25 *rule;*
26 *Readopted Eff. January 1, ~~2017~~ 2017;*
27 *Amended Eff. July 1, 2018.*

1 10A NCAC 13P .0201 is amended as published in 32:11 NCR 1026-1036 as follows:

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3 **10A NCAC 13P .0201 EMS SYSTEM REQUIREMENTS**

4 (a) County governments shall establish EMS Systems. Each EMS System shall have:

5 (1) a defined geographical service area for the EMS System. The minimum service area for an EMS
6 System shall be one county. There may be multiple EMS Provider service areas within an EMS
7 System. The highest level of care offered within any EMS Provider service area shall be available
8 to the citizens within that service area 24 hours a day, seven days a week;

9 (2) a defined scope of practice for all EMS personnel functioning in the EMS System within the
10 parameters set forth by the North Carolina Medical Board pursuant to G.S. 143-514;

11 (3) written policies and procedures describing the dispatch, coordination, and oversight of all
12 responders that provide EMS care, specialty patient care skills, and procedures as set forth in
13 Rule ~~.0301(a)(4)~~ .0301 of this Subchapter, and ambulance transport within the system;

14 (4) at least one licensed EMS Provider;

15 (5) a listing of permitted ambulances to provide coverage to the service area 24 hours a day, seven days
16 a week;

17 (6) personnel credentialed to perform within the scope of practice of the system and to staff the
18 ambulance vehicles as required by G.S. 131E-158. There shall be a written plan for the use of
19 credentialed EMS personnel for all practice settings used within the system;

20 (7) written policies and procedures specific to the utilization of the EMS System's EMS Care data for
21 the daily and on-going management of all EMS System resources;

22 (8) a written Infectious Disease Control Policy as defined in Rule ~~.0102(28)~~ .0102 of this Subchapter
23 and written procedures that are approved by the EMS System Medical Director that address the
24 cleansing and disinfecting of vehicles and equipment that are used to treat or transport patients;

25 (9) a listing of resources that will provide online medical direction for all EMS Providers operating
26 within the EMS System;

27 (10) an EMS communication system that provides for:

28 (A) public access to emergency services by dialing 9-1-1 within the public dial telephone
29 network as the primary method for the public to request emergency assistance. This
30 number shall be connected to the PSAP with immediate assistance available such that no
31 caller will be instructed to hang up the telephone and dial another telephone number. A
32 person calling for emergency assistance shall not be required to speak with more than two
33 persons to request emergency medical assistance;

34 (B) a PSAP operated by public safety telecommunicators with training in the management of
35 calls for medical assistance available 24 hours a day, seven days a week;

36 (C) dispatch of the most appropriate emergency medical response unit or units to any caller's
37 request for assistance. The dispatch of all response vehicles shall be in accordance with a

- 1 written EMS System plan for the management and deployment of response vehicles
2 including requests for mutual aid; and
- 3 (D) two-way radio voice communications from within the defined service area to the PSAP
4 and to facilities where patients are transported. The PSAP shall maintain all required FCC
5 radio licenses or authorizations;
- 6 (11) written policies and procedures for addressing the use of SCTP and Air Medical Programs resources
7 utilized within the system;
- 8 (12) a written continuing education program for all credentialed EMS personnel, under the direction of
9 a System Continuing Education Coordinator, developed and modified based on feedback from EMS
10 Care system data, review, and evaluation of patient outcomes and quality management peer reviews,
11 that follows the criteria set forth in Rule .0501 of this Subchapter;
- 12 (13) written policies and procedures to address management of the EMS System that includes:
- 13 (A) triage and transport of all acutely ill and injured patients with time-dependent or other
14 specialized care issues including trauma, stroke, STEMI, burn, and pediatric patients that
15 may require the by-pass of other licensed health care facilities and that are based upon the
16 expanded clinical capabilities of the selected healthcare facilities;
- 17 (B) triage and transport of patients to facilities outside of the system;
- 18 (C) arrangements for transporting patients to identified facilities when diversion or bypass
19 plans are activated;
- 20 (D) reporting, monitoring, and establishing standards for system response times using system
21 data;
- 22 (E) weekly updating of the SMARTT EMS Provider information;
- 23 (F) a disaster plan;
- 24 (G) ~~a mass-gathering plan;~~ plan that includes how the provision of EMS standby coverage for
25 the public-at-large will be provided;
- 26 (H) a mass-casualty plan;
- 27 (I) a weapons plan for any weapon as set forth in Rule .0216 of this Section;
- 28 (J) a plan on how EMS personnel shall report suspected child abuse pursuant to G.S. 7B-301;
- 29 (K) a plan on how EMS personnel shall report suspected abuse of the disabled pursuant to G.S.
30 108A-102; and
- 31 (L) a plan on how each responding agency is to maintain a current roster of its personnel
32 providing EMS care within the county under the provider number issued pursuant to
33 Paragraph (c) of this Rule, in the OEMS credentialing and information database;
- 34 (14) affiliation as defined in Rule ~~.0102(3)~~ .0102 of this Subchapter with a trauma RAC as required by
35 Rule .1101(b) of this Subchapter; and
- 36 (15) medical oversight as required by Section .0400 of this Subchapter.

1 (b) Each EMS System that utilizes emergency medical dispatching agencies applying the principles of EMD or
2 offering EMD services, procedures, or programs to the public shall have:

- 3 (1) a defined service area for each agency;
- 4 (2) appropriate personnel within each agency, credentialed in accordance with the requirements set forth
5 in Section .0500 of this Subchapter, to ensure EMD services to the citizens within that service area
6 are available 24 hours per day, seven days a week; and
- 7 (3) EMD responsibilities in special situations, such as disasters, mass-casualty incidents, or situations
8 requiring referral to specialty hotlines.

9 (c) The EMS System shall obtain provider numbers from the OEMS for each entity that provides EMS Care within
10 the county.

11 (d) An application to establish an EMS System shall be submitted by the county to the OEMS for review. When the
12 system is comprised of more than one county, only one application shall be submitted. The proposal shall demonstrate
13 that the system meets the requirements in Paragraph (a) of this Rule. System approval shall be granted for a period of
14 six years. Systems shall apply to OEMS for reapproval no more than 90 days prior to expiration.

15
16 *History Note: Authority G.S. 131E-155(1); 131E-155(6); 131E-155(7); 131E-155(8); 131E-155(9); 131E-*
17 *155(13a); 131E-155(15); 143-508(b); 143-508(d)(1); 143-508(d)(2); 143-508(d)(3); 143-*
18 *508(d)(5); 143-508(d)(8); 143-508(d)(9); 143-508(d)(10); 143-508(d)(13); 143-517; 143-518;*
19 *Temporary Adoption Eff. January 1, 2002;*
20 *Eff. August 1, 2004;*
21 *Amended Eff. January 1, 2009;*
22 *Readopted Eff. January 1, ~~2017~~ 2017;*
23 *Amended Eff. July 1, 2018.*

1 10A NCAC 13P .0222 is amended as published in 32:11 NCR 1026-1036 as follows:

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3 **10A NCAC 13P .0222 TRANSPORT OF STRETCHER BOUND PATIENTS**

4 (a) Any person transported on a stretcher as defined in Rule ~~.0102(49)~~ .0102 of this Subchapter meets the definition
5 of patient as defined in G.S. 131E-155(16).

6 (b) Stretchers may only be utilized for patient transport in an ambulance permitted by the OEMS in accordance with
7 G.S. 131E-156 and Rule .0211 of this Section.

8 (c) The Medical Care Commission exempts wheeled chair devices used solely for the transportation of mobility
9 impaired persons in non-permitted vehicles from the definition of stretcher.

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11 *History Note: Authority G.S. 131E-156; 131E-157; 143-508(d)(8);*

12 *Eff. January 1, ~~2017~~ 2017;*

13 *Amended Eff. July 1, 2018.*

MCC Action: Final Adoption

1 10A NCAC 13P .0301 is amended as published in 32:11 NCR 1026-1036 as follows:

2

3 **10A NCAC 13P .0301 SPECIALTY CARE TRANSPORT PROGRAM CRITERIA**

4 (a) EMS Providers seeking designation to provide specialty care transports shall submit an application for program
5 approval to the OEMS at least 60 days prior to field implementation. The application shall document that the program
6 has:

7 (1) a defined service area that identifies the specific transferring and receiving facilities the program is
8 intended to service;

9 (2) written policies and procedures implemented for medical oversight meeting the requirements of
10 Section .0400 of this Subchapter;

11 (3) ~~Service~~ service available on a 24 hour a day, seven days a week basis;

12 (4) the capability to provide the patient care skills and procedures as specified in "North Carolina
13 College of Emergency Physicians: Standards for Medical Oversight and Data Collection;"

14 (5) a written continuing education program for EMS personnel, under the direction of the Specialty
15 Care Transport Program Continuing Education Coordinator, developed and modified based upon
16 feedback from program data, review and evaluation of patient outcomes, and quality management
17 review that follows the criteria set forth in Rule .0501 of this Subchapter;

18 (6) a communication system that provides two-way voice communications for transmission of patient
19 information to medical crew members anywhere in the service area of the program. The SCTP
20 Medical Director shall verify that the communications system is satisfactory for on-line medical
21 direction;

22 (7) medical crew members that have completed training conducted every six months regarding:

23 (A) operation of the EMS communications system used in the program; and

24 (B) the medical and patient safety equipment specific to the program;

25 (8) written operational protocols for the management of equipment, supplies, and medications. These
26 protocols shall include:

27 (A) a listing of all standard medical equipment, supplies, and medications, approved by the
28 Medical Director as sufficient to manage the anticipated number and severity of injury or
29 illness of the patients, for all vehicles used in the program based on the treatment protocols
30 and approved by the OEMS; and

31 (B) a methodology to ensure that each ground vehicle and aircraft contains the required
32 equipment, supplies, and medications on each response; and

33 (9) written policies and procedures specifying how EMS Systems will dispatch and utilize the ground
34 ambulances and aircraft operated by the program.

35 (b) When transporting patients, staffing for the ground ambulance and aircraft used in the SCTP shall be approved by
36 the SCTP Medical Director as medical crew members, using any of the following as determined by the transferring

1 physician who is responsible for the medical aspects of the mission to manage the anticipated severity of injury or
2 illness of the patient:

- 3 (1) paramedic;
- 4 (2) nurse practitioner;
- 5 (3) physician;
- 6 (4) physician assistant;
- 7 (5) registered nurse; or
- 8 (6) respiratory therapist.

9 (c) SCTP as defined in Rule ~~0102(47)~~ .0102 of this Subchapter are exempt from the staffing requirements defined in
10 G.S. 131E-158(a).

11 (d) SCTP approval is valid for a period to coincide with the EMS Provider License that is issued by OEMS and is
12 valid for six years. Programs shall apply to the OEMS for ~~reapproval~~ reapproval no more than 90 days prior to
13 expiration.

14
15 *History Note: Authority G.S. 131E-155.1(b); 131E-158; 143-508;*
16 *Temporary Adoption Eff. January 1, 2002;*
17 *Eff. January 1, 2004;*
18 *Amended Eff. January 1, 2004;*
19 *Amended Eff. March 3, 2009 pursuant to E.O. 9, Beverly Perdue, March 3, 2009;*
20 *Pursuant to G.S. 150B-21.3(c), a bill was not ratified by the General Assembly to disapprove this*
21 *rule;*
22 *Readopted Eff. January 1, ~~2017~~ 2017;*
23 *Amended Eff. July 1, 2018.*

MCC Action: Final Adoption

1 10A NCAC 13P .0505 is amended as published in 32:11 NCR 1026-1036 as follows:

2

3 **10A NCAC 13P .0505 SCOPE OF PRACTICE FOR EMS PERSONNEL**

4 EMS Personnel educated in approved programs, credentialed by the OEMS, and ~~affiliated with an approved EMS~~
5 ~~System~~ functioning under physician medical oversight may perform acts and administer intravenous fluids and
6 medications as allowed by the North Carolina Medical Board pursuant to G.S. 143-514.

7

8 *History Note: Authority G.S. 143-508(d)(6); 143-514;*

9 *Temporary Adoption Eff. January 1, 2002;*

10 *Eff. April 1, 2003;*

11 *Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February*
12 *2, ~~2016,~~ 2016;*

13 *Amended Eff. July 1, 2018.*

MCC Action: Final Adoption

1 10A NCAC 13P .0506 is amended as published in 32:11 NCR 1026-1036 as follows:

2

3 **10A NCAC 13P .0506 PRACTICE SETTINGS FOR EMS PERSONNEL**

4 (a) Credentialed EMS Personnel may function in the following practice settings in accordance with the protocols
5 approved by the OEMS and by the Medical Director of the EMS System or Specialty Care Transport Program with
6 which they are affiliated:

7 (1) at the location of a physiological or psychological illness or ~~injury, including transportation to a~~
8 ~~treatment facility if required;~~ injury;

9 (2) at public or community health facilities in conjunction with public and community health initiatives;

10 (3) in hospitals and clinics;

11 (4) in residences, facilities, or other locations as part of wellness or injury prevention initiatives within
12 the community and the public health system; ~~and~~

13 (5) at mass gatherings or special ~~events.~~ events; and

14 (6) community paramedicine programs.

15 (b) Individuals functioning in an alternative practice setting as defined in Rule ~~.0102(4)~~ .0102 of this Subchapter
16 consistent with the areas identified in Subparagraphs ~~(a)(2)~~ (a)(1) through ~~(a)(4)~~ (a)(5) of this Rule that are not
17 affiliated with an EMS System shall:

18 (1) be under the medical oversight of a physician licensed by the North Carolina Medical Board that is
19 associated with the practice setting where the individual will function; and

20 (2) be restricted to performing within the scope of practice as defined by the North Carolina Medical
21 Board pursuant to G.S. 143-514 for the individual's level of EMS credential.

22 (c) Individuals holding a valid EMR or EMT credential that are not affiliated with an approved first responder program
23 or EMS agency and that do not administer medications or utilize advanced airway devices are approved to function
24 as a member of an industrial or corporate first aid safety team without medical oversight or EMS System affiliation.

25

26 *History Note: Authority G.S. 143-508(d)(7);*

27 *Temporary Adoption Eff. January 1, 2002;*

28 *Eff. April 1, 2003;*

29 *Amended Eff. January 1, 2004;*

30 *Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2,*
31 *2016;*

32 *Amended Eff. July 1, 2018; January 1, 2017.*

1 10A NCAC 13P .0904 is amended as published in 32:11 NCR 1026-1036 as follows:

2

3 **10A NCAC 13P .0904 INITIAL DESIGNATION PROCESS**

4 (a) For initial Trauma Center designation, the hospital shall request a consult visit by OEMS and the consult shall
5 occur within one year prior to submission of the RFP.

6 (b) A hospital interested in pursuing Trauma Center designation shall submit a letter of intent 180 days prior to the
7 submission of an RFP to the OEMS. The letter shall define the hospital's primary trauma catchment area.
8 Simultaneously, Level I or II applicants shall also demonstrate the need for the Trauma Center designation by
9 submitting one original and three copies of documents that include:

10 (1) the population to be served and the extent that the population is underserved for trauma care with
11 the methodology used to reach this conclusion;

12 (2) geographic considerations, to include trauma primary and secondary catchment area and distance
13 from other Trauma Centers; and

14 (3) evidence the Trauma Center will admit at least 1200 trauma patients ~~yearly~~ annually or show that
15 its trauma service will be taking care of at least 240 trauma patients with an ISS greater than or equal
16 to 15 yearly. These criteria shall be met without compromising the quality of care or cost
17 effectiveness of any other designated Level I or II Trauma Center sharing all or part of its catchment
18 area or by jeopardizing the existing Trauma Center's ability to meet this same 240-patient minimum.

19 (c) The hospital shall be participating in the State Trauma Registry as defined in Rule ~~.0102(61)~~ .0102 of this
20 Subchapter, and submit data to the OEMS weekly a minimum of 12 months prior to application that includes all the
21 Trauma Center's trauma patients as defined in Rule ~~.0102(59)~~ .0102 of this Subchapter who are:

22 (1) diverted to an affiliated hospital;

23 (2) admitted to the Trauma Center for greater than 24 hours from an ED or hospital;

24 (3) die in the ED;

25 (4) are DOA; or

26 (5) are transferred from the ED to the OR, ICU, or another hospital (including transfer to any affiliated
27 hospital).

28 (d) OEMS shall review the regional Trauma Registry data from both the applicant and the existing trauma center(s),
29 and ascertain the applicant's ability to satisfy the justification of need information required in ~~Subparagraphs (b)(1)~~
30 ~~through (3) Paragraph (b)~~ of this Rule. The OEMS shall notify the applicant's primary RAC of the application and
31 provide the regional data submitted by the applicant in ~~Subparagraphs (b)(1) through (3) Paragraph (b)~~ of this Rule
32 for review and comment. The RAC shall be given 30 days to submit written comments to the OEMS.

33 (e) OEMS shall notify the respective Board of County Commissioners in the applicant's primary catchment area of
34 the request for initial designation to allow for comment during the same 30 day comment period.

35 (f) OEMS shall notify the hospital in writing of its decision to allow submission of an RFP. If approved, the RAC
36 and Board of County Commissioners in the applicant's primary catchment area shall also be notified by the OEMS
37 that an RFP will be submitted.

1 (g) Once the hospital is notified that an RFP will be accepted, the hospital shall complete and submit an electronic
2 copy of the completed RFP with signatures to the OEMS at least 45 days prior to the proposed site visit date.

3 (h) The RFP shall demonstrate that the hospital meets the standards for the designation level applied for as found in
4 Rule .0901 of this Section.

5 (i) If OEMS does not recommend a site visit based upon failure to comply with Rule .0901 of this Section, the OEMS
6 shall send the written reasons to the hospital within 30 days of the decision. The hospital may reapply for designation
7 within six months following the submission of an updated RFP. If the hospital fails to respond within six months, the
8 hospital shall reapply following the process outlined in Paragraphs (a) through (h) of this Rule.

9 (j) If after review of the RFP, the OEMS recommends the hospital for a site visit, the OEMS shall notify the hospital
10 within 30 days and the site visit shall be conducted within six months of the recommendation. The hospital and the
11 OEMS shall agree on the date of the site visit.

12 (k) Except for OEMS representatives, any in-state reviewer for a Level I or II visit shall be from outside the local or
13 adjacent RAC, unless mutually agreed upon by the OEMS and the trauma center seeking designation where the
14 hospital is located. The composition of a Level I or II state site survey team shall be as follows:

- 15 (1) one out-of-state trauma surgeon who is a Fellow of the ACS, experienced as a site surveyor, who
16 shall be the primary reviewer;
- 17 (2) one in-state emergency physician who currently works in a designated trauma center, is a member
18 of the American College of Emergency Physicians or American Academy of Emergency Medicine,
19 and is boarded in emergency medicine by the American Board of Emergency Medicine or the
20 American Osteopathic Board of Emergency Medicine;
- 21 (3) one in-state trauma surgeon who is a member of the North Carolina Committee on Trauma;
- 22 (4) for Level I designation, one out-of-state trauma program manager with an equivalent license from
23 another state;
- 24 (5) for Level II designation, one in-state program manager who is licensed to
25 practice ~~professional~~ nursing in North Carolina in accordance with the Nursing Practice Act, Article
26 9A, Chapter 90 of the North Carolina General Statutes; and
- 27 (6) OEMS Staff.

28 (l) All site team members for a Level III visit shall be from in-state, and, except for the OEMS representatives, shall
29 be from outside the local or adjacent RAC where the hospital is located. The composition of a Level III state site
30 survey team shall be as follows:

- 31 (1) one trauma surgeon who is a Fellow of the ACS, who is a member of the North Carolina Committee
32 on Trauma and shall be the primary reviewer;
- 33 (2) one emergency physician who currently works in a designated trauma center, is a member of the
34 North Carolina College of Emergency Physicians or American Academy of Emergency Medicine,
35 and is boarded in emergency medicine by the American Board of Emergency Medicine or the
36 American Osteopathic Board of Emergency Medicine;

1 (3) one trauma program manager who is licensed to practice ~~professional~~ nursing in North Carolina in
2 accordance with the Nursing Practice Act, Article 9A, Chapter 90 of the North Carolina General
3 Statutes; and

4 (4) OEMS Staff.

5 (m) On the day of the site visit, the hospital shall make available all requested patient medical charts.

6 (n) The primary reviewer of the site review team shall give a verbal post-conference report representing a consensus
7 of the site review team. The primary reviewer shall complete and submit to the OEMS a written consensus report
8 within 30 days of the site visit.

9 (o) The report of the site survey team and the staff recommendations shall be reviewed by the State Emergency
10 Medical Services Advisory Council at its next regularly scheduled meeting following the site visit. Based upon the
11 site visit report and the staff recommendation, the State Emergency Medical Services Advisory Council shall
12 recommend to the OEMS that the request for Trauma Center designation be approved or denied.

13 (p) All criteria defined in Rule .0901 of this Section shall be met for initial designation at the level requested.

14 (q) Hospitals with a deficiency(ies) resulting from the site visit shall be given up to 12 months to demonstrate
15 compliance. Satisfaction of deficiency(ies) may require an additional site visit. The need for an additional site
16 visit ~~is~~ shall be determined on a case-by-case basis based on the type of deficiency. If compliance is not demonstrated
17 within the time period set by OEMS, the hospital shall submit a new application and updated RFP and follow the
18 process outlined in Paragraphs (a) through (h) of this Rule.

19 (r) The final decision regarding Trauma Center designation shall be rendered by the OEMS.

20 (s) The OEMS shall notify the hospital in writing of the State Emergency Medical Services Advisory Council's and
21 OEMS' final recommendation within 30 days of the Advisory Council meeting.

22 (t) If a trauma center changes its trauma program administrative structure such that the trauma service, trauma Medical
23 Director, trauma program manager, or trauma registrar are relocated on the hospital's organizational chart at any time,
24 it shall notify OEMS of this change in writing within 30 days of the occurrence.

25 (u) Initial designation as a trauma center shall be valid for a period of three years.

26
27 *History Note: Authority G.S. 131E-162; 143-508(d)(2);*
28 *Temporary Adoption Eff. January 1, 2002;*
29 *Eff. April 1, 2003;*
30 *Amended Eff. January 1, 2009;*
31 *Readopted Eff. January 1, ~~2017~~ 2017;*
32 *Amended Eff. July 1, 2018.*

MCC Action: Final Adoption

1 10A NCAC 13P .1502 is amended as published in 32:11 NCR 1026-1036 as follows:

2

3 **10A NCAC 13P .1502 LICENSED EMS PROVIDERS**

4 (a) The OEMS shall deny an initial or renewal EMS Provider license for any of the following reasons:

5 (1) significant failure to comply, as defined in Rule ~~.0102(45)~~ .0102 of this Subchapter, with the
6 applicable licensing requirements in Rule .0204 of this Subchapter;

7 (2) making false statements or representations to the OEMS or willfully concealing information in
8 connection with an application for licensing;

9 (3) tampering with or falsifying any record used in the process of obtaining an initial license or in the
10 renewal of a license; or

11 (4) disclosing information as defined in Rule .0223 of this Subchapter that is determined by
12 OEMS ~~staff~~ staff, based upon review of documentation, to disqualify the applicant from licensing.

13 (b) The Department shall amend any EMS Provider license by amending it to reduce the license from a full license
14 to a provisional license whenever the Department finds that:

15 (1) the licensee failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under
16 that Article;

17 (2) there is a probability that the licensee can take corrective measures to resolve the issue of non-
18 compliance with Rule .0204 of this Subchapter, and be able ~~thereafter~~ to remain in compliance
19 within a reasonable length of time determined by OEMS staff on a case-by-case basis; and

20 (3) there is a probability, determined by OEMS staff using their professional judgment, based upon
21 analysis of the licensee's ability to take corrective measures to resolve the issue of non-compliance
22 with the licensure rules, that the licensee will be able thereafter to remain in compliance with the
23 licensure rules.

24 (c) The Department shall give the licensee written notice of the amendment of the EMS Provider license. This notice
25 shall be given personally or by certified mail and shall set forth:

26 (1) the duration of the provisional EMS Provider license;

27 (2) the factual allegations;

28 (3) the statutes or rules alleged to be violated; and

29 (4) notice of the EMS provider's right to a contested case hearing, as set forth in Rule .1509 of this
30 Subchapter, on the amendment of the EMS Provider license.

31 (d) The provisional EMS Provider license is effective upon its receipt by the licensee and shall be posted in a location
32 at the primary business location of the EMS Provider, accessible to public view, in lieu of the full license. Pursuant
33 to G.S. 131E-155.1(d), the provisional license remains in effect until the Department:

34 (1) restores the licensee to full licensure status; or

35 (2) revokes the licensee's license.

36 (e) The Department shall revoke or suspend an EMS Provider license whenever the Department finds that the licensee:

- 1 (1) failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under that Article
2 and it is not probable that the licensee can remedy the licensure deficiencies within 12 months or
3 less;
- 4 (2) failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under that Article
5 and, although the licensee may be able to remedy the deficiencies, it is not probable that the licensee
6 will be able to remain in compliance with licensure rules;
- 7 (3) failed to comply with the provision of G.S. 131E, Article 7, and the rules adopted under that Article
8 that endanger the health, safety, or welfare of the patients cared for or transported by the licensee;
- 9 (4) obtained or attempted to obtain an ambulance permit, EMS nontransporting vehicle permit, or EMS
10 Provider license through fraud or misrepresentation;
- 11 (5) continues to repeat the same deficiencies placed on the licensee in previous compliance site visits;
- 12 (6) has recurring failure to provide emergency medical care within the defined EMS service area in a
13 manner as determined by the EMS System;
- 14 (7) failed to disclose or report information in accordance with Rule .0223 of this Subchapter;
- 15 (8) was deemed by OEMS to place the public at risk because the ~~owner~~ owner, or any ~~officer~~ officer,
16 or agent was convicted in any court of a crime involving fiduciary misconduct or a conviction of a
17 felony;
- 18 (9) altered, destroyed, attempted to destroy, withheld, or delayed release of evidence, records, or
19 documents needed for a complaint investigation being conducted by the OEMS; or
- 20 (10) continues to operate within an EMS System after a Board of County Commissioners ~~has~~ terminated
21 its affiliation with the licensee, resulting in a violation of the licensing requirement set forth in
22 Rule ~~.0204(a)(4)~~ .0204 of this Subchapter.

23 (f) The Department shall give the EMS Provider written notice of revocation. This notice shall be given personally
24 or by certified mail and shall set forth:

- 25 (1) the factual allegations;
- 26 (2) the statutes or rules alleged to be violated; and
- 27 (3) notice of the EMS Provider's right to a contested case hearing, as set forth in Rule .1509 of this
28 Section, on the revocation of the EMS Provider's license.

29 (g) The issuance of a provisional EMS Provider license is not a procedural prerequisite to the revocation or suspension
30 of a license pursuant to Paragraph (e) of this Rule.

31
32 *History Note: Authority G.S. 131E-155.1(d); 143-508(d)(10);*

33 *Eff. January 1, 2013;*

34 *Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2,*
35 *2016;*

36 *Amended Eff. July 1, 2018; January 1, 2017.*

MCC Action: Final Adoption

1 10A NCAC 13P .1505 is amended as published in 32:11 NCR 1026-1036 as follows:

2

3 **10A NCAC 13P .1505 EMS EDUCATIONAL INSTITUTIONS**

4 (a) For the purpose of this Rule, "focused review" means an evaluation by the OEMS of an educational institution's
5 corrective actions to remove contingencies that are a result of deficiencies identified in the initial or renewal
6 application process.

7 (b) The Department shall deny the initial or renewal designation, without first allowing a focused review, of an EMS
8 Educational Institution for any of the following reasons:

- 9 (1) significant failure to comply with the provisions of Section .0600 of this Subchapter; or
- 10 (2) attempting to obtain an EMS Educational Institution designation through fraud or misrepresentation.

11 (c) When an EMS Educational Institution is required to have a focused review, it shall demonstrate compliance with
12 the provisions of Section .0600 of this Subchapter within 12 months or less.

13 (d) The Department shall revoke an EMS Educational Institution designation at any time whenever the Department
14 finds that the EMS Educational Institution has significant failure to comply, as defined in Rule ~~.0102(45)~~ .0102 of this
15 Subchapter, with the provisions of Section .0600 of this Subchapter, and:

- 16 (1) it is not probable that the EMS Educational Institution can remedy the deficiencies within 12 months
17 or less as determined by OEMS staff based upon analysis of the educational institution's ability to
18 take corrective measures to resolve the issue of non-compliance with Section .0600 of this
19 Subchapter;
- 20 (2) although the EMS Educational Institution may be able to remedy the deficiencies, it is not probable
21 that the EMS Educational Institution shall be able to remain in compliance with credentialing rules;
- 22 (3) failure to produce records upon request as required in Rule .0601(b)(6) of this Subchapter;
- 23 (4) the EMS Educational Institution failed to meet the requirements of a focused review within 12
24 months, as set forth in Paragraph (c) of this Rule;
- 25 (5) the failure to comply endangered the health, safety, or welfare of patients cared for as part of an
26 EMS educational program as determined by OEMS staff in their professional judgment based upon
27 a complaint investigation, in consultation with the Department and Department of Justice, to verify
28 the results of the investigations are sufficient to initiate enforcement action pursuant to G.S. 150B;
29 or
- 30 (6) the EMS Educational Institution altered, destroyed, or attempted to destroy evidence needed for a
31 complaint investigation.

32 (e) The Department shall give the EMS Educational Institution written notice of revocation and denial. This notice
33 shall be given personally or by certified mail and shall set forth:

- 34 (1) the factual allegations;
- 35 (2) the statutes or rules alleged to be violated; and
- 36 (3) notice of the EMS Educational Institution's right to a contested case hearing, set forth in Rule .1509
37 of this Section, on the revocation of the designation.

1 (f) Focused review is not a procedural prerequisite to the revocation of a designation as set forth in Rule .1509 of this
2 Section.

3 (g) If determined by the educational institution that suspending its approval to offer EMS educational programs is
4 necessary, the EMS Educational Institution may voluntarily surrender its credential without explanation by submitting
5 a written request to the OEMS stating its intention. The voluntary surrender shall not affect the original expiration
6 date of the EMS Educational Institution's designation. To reactivate the designation:

- 7 (1) the institution shall provide OEMS written documentation requesting reactivation; and
- 8 (2) the OEMS shall verify the educational institution is compliant with all credentialing requirements
9 set forth in Section .0600 of this Subchapter prior to reactivation of the designation by the OEMS.

10 (h) If the institution fails to resolve the issues that resulted in a voluntary surrender, the Department shall revoke the
11 EMS Educational Institution designation.

12 (i) In the event of a revocation or voluntary surrender, the Department shall provide written notification to all EMS
13 Systems within the EMS Educational Institution's defined service area. The Department shall provide written
14 notification to all EMS Systems within the EMS Educational Institution's defined service area when the voluntary
15 surrender reactivates to full credential.

16 (j) When an accredited EMS Educational Institution as defined in Rule .0605 of this Subchapter has administrative
17 action taken against its accreditation, the OEMS shall determine if the cause of action is sufficient for revocation of
18 the EMS Educational Institution designation or imposing a focused review pursuant to Paragraphs (b) and (c) of this
19 Rule is warranted.

20
21 *History Note: Authority G.S. 143-508(d)(4); 143-508(d)(10);*
22 *Eff. January 1, 2013;*
23 *Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2,*
24 *2016;*
25 *Amended Eff. July 1, 2018; January 1, 2017.*

Emergency Services and Trauma Rules Amendments Public Comments
 10A NCAC 13P .0102, .0201, .0222, .0301, .0505, .0506, .0904, .1502 and .1505
 Comment Period 12/01/17 – 01/30/18

Introduction:

There were three individual comments received, one being a duplicate, during the public comment period on the re-adoption of Rules 10A NCAC 13P .0102, .0201, .0222, .0301, .0505, .0506, .0904, .1502 and .1505. These comments were submitted by representatives from the North Carolina Board of Nursing and Novant Health Presbyterian Medical Center. All of the comments received on these rules are summarized below:

1) Listing of Comments Received and Agency’s Consideration of Comments for Re-adoption Rule 13P .0102 - Definitions:

Commenter	Comment Summary
NC Board of Nursing	<p>The definition of “Assistant Medical Director” was not changed to reflect the proposed change to the definition of “Medical Director.”</p> <p><u>Recommend:</u> amend the definition of “Assistant Medical Director” to reflect the specific wording as the proposed change in the “Medical Director” definition.</p>

Agency Response to Comments Above:

OEMS will adopt the comments from the NC Board of Nursing. The change will provide the consistency to better needed to clarify “Assistant Medical Director,” and properly align the definition with the role of the “Medical Director.”

2) Listing of Comments Received and Agency’s Consideration of Comments for Re-adoption Rule 13P .0904 – Initial Designation Process:

Commenter	Comment Summary
Novant Health Presbyterian Medical Center (Duplicate submitted: one via email and one via fax)	<p>When N.C. recently adopted the American College of Surgeons (ACS) criteria for trauma centers, it failed to update conflicting portions of this rule, and it should be updated to align with the ACS requirements. Prior to the change in the trauma rules, NC had its own criteria for hospitals seeking Level I & II designations in that for these levels, a trauma service was to serve the same number of trauma patients per year with an Injury Severity Score greater than or equal to 15. This provision lumping the Level I & II designations together remains in the rule and is in direct conflict with the ACS requirements for a Level II trauma designation.</p> <p>Level I & Level II trauma centers are distinguished differently in the ACS requirements. Level I centers have requirements for minimum patient admissions, a surgically directed critical care service, education, and research. Level II trauma centers do not have minimum admission requirements as they do not have research or education requirements. The purpose of the Level II trauma center is to supplement the clinical activity and expertise of the Level I centers, therefore the admission requirements as currently written, are unwarranted and impede the ability to create a tiered trauma system that ensures a cooperative environment among trauma centers. It also impedes</p>

Commenter	Comment Summary
	<p>establishment of such a system by impeding a competitive environment and impacts the hospital's abilities to increase the level of trauma care provided to the citizens.</p> <p>The trauma rules in the neighboring states either followed the ACS requirements or did not specify admission volumes for trauma designation. Since rule 13P .0901 already requires ACS compliance for designation, there would be no need for volume requirements in rule 13P .0904. Conflicts would also be alleviated between the 13P rules should ACS update volume requirements in the future. The changes would help ensure continued provision of optimal trauma care for North Carolinians.</p>

Agency Response to Comments Above:

Trauma Center Designation by the NCOEMS is a voluntary "process." Rule .0904 is a means to demonstrate the need for Trauma Center designation. The American College of Surgeons (ACS) conducts Trauma Center Verification, an evaluation process to verify the presence of the resources defined in "Resources of Optimal Care of the Injured Patient." The NCOEMS considers the requirements in .0904(b)(3) vital to adequately demonstrate the need for Trauma Center Designation therefore, the NCOEMS will not adopt this comment.

**DHHS / OSBM Review
Permanent Rule Adoption With Substantial Economic Impact**

Agencies Proposing Rule Change

North Carolina Medical Care Commission

Contact Persons

Nadine Pfeiffer, DHSR Rule Making Manager – (919) 855-3811

Tom Mitchell, OEMS Chief – (919) 855-3941

Wally Ainsworth, OEMS Central Regional Manager – (919) 855-4680

Overview

State Government Impact Yes

Local Government Impact Yes

Private Sector Impact Yes

Substantial Economic Impact Yes

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Appendix A: The EMS and Trauma Rules under revision 10A NCAC 13P.

Appendix B: Community Paramedicine Pilot Program: Report to the Joint Legislative Oversight Committee on Health and Human Services and Fiscal Research Division

Authorizing Statutes

The following statutes are cited in the statutory authority of the rules under revision by the MCC.

G.S. 131E-155

G.S. 131E-156

G.S. 131E-158

G.S. 131E-162

G.S. 143-508

Titles of Rule Changes Proposed for Amendment

The following rules reflect the changes needed to update unnecessary standards, clarify ambiguous language, incorporate changes in practice settings due to new initiatives, and to provide all regulated entities and the public the most efficient and effective structure for services regulated for emergency medical and trauma systems.

10A NCAC 13P (*See proposed text of these rules as Appendix A.*)

Section .0100 – Definitions

.0102 – Definitions (Amend)

Section .200 – EMS Systems

.0201 – EMS System Requirement (Amend)

.0222 – Transport of Stretcher Bound Patients (Amend)

Section .0300 – Specialty Care Transport Programs

.0301 – Specialty Care Transport Program Criteria (Amend)

Section .0500 – EMS Personnel

.0505 – Scope of Practice for EMS Personnel (Amend)

.0506 – Practice Settings for EMS Personnel (Amend)

Section 0900 – Trauma Center Standards and Approval

.0904 – Initial Designation Process (Amend)

Section .1500 – Denial, Suspension, Amendment, or Revocation

.1502 – Licensed EMS Providers (Amend)

.1505 – EMS Educational Institutions (Amend)

Five rules are being amended with technical changes only with no economic impact: Rules .0222, .0301, .0904, .1502, and .1505.

The following sections of this report will analyze the expected costs and benefits of the rule amendments with economic impact:

- Change the setting and medical oversight of EMS-credentialed personnel to facilitate the formation of Community Paramedic/Mobile Integrated Healthcare programs (Rules .0102, .0505, .0506)
- Include federal facilities in the definition of a hospital (Rule .0102)
- Require local EMS Systems to provide mass gathering plans to OEMS for review upon request (Rule .0201)

Analysis: Community Paramedic (CP)/Mobile Integrated Health (MIH) Program

Community Paramedic/Mobile Integrated Healthcare Program Background

Statewide as well as nationally, growing challenges are adversely impacting healthcare facilities and EMS organizations. In most areas emergency departments and EMS agencies are becoming the safety net for non-emergency healthcare. “Repeat” users of EMS further compound these already overburdened services.ⁱ

Emergency department overcrowding has been well documented in recent years. Many of the public are using the emergency departments as a source of primary care.ⁱⁱ Mental health and substance abuse patients consistently spend numerous hours in the emergency department in order to get medical clearance for admission to an appropriate treatment facility.ⁱⁱⁱ Chronic disease patients that are readmitted to a hospital within an established timeframe and are no longer eligible for reimbursement, placing more pressure on healthcare facilities not only to manage these patients during their stay but also after discharge.^{iv}

Under normal circumstances the EMS response results in the patient being transported to the emergency department, whether the “chief complaint” is an emergency or not. Individuals suffering from mental health/substance abuse account for a large proportion of repeat users^v and can overwhelm an EMS agency and the hospitals. The negative impacts are both in operational efficiency (lost/unproductive unit hours and bed capacity), increasing costs, and poor patient outcomes.

A solution requires “out of the box” ideas that go well beyond the typical 911 EMS ambulance response. If insanity is doing the same thing over and over again expecting different results, what does this say about the current system? The EMS response has to become more efficient and more focus placed on the patient outcome after the EMS assessment and the healthcare facility discharge. An EMS ambulance response is no longer the most appropriate means to meet the needs of these patients.

Existing reimbursement mechanisms do not reward EMS systems or hospital systems for providing the appropriate care in the most appropriate setting or providing post-discharge services to prevent readmissions. EMS reimbursement is tied to “transport” of the patient to a hospital, making even “outside the box” ideas or solutions a fiscal nightmare. CP/MIH programs often seek a way to avoid unnecessarily transporting patients to the Emergency Department. As a result, EMS must absorb the expense of the program as well as the foregone revenue from reduced transports. In many cases, EMS is incentivized to do the wrong thing for the patient if they want to be paid for their service.

Proposed Interventions

A national trend has redefined a more appropriate response to these issues, community paramedic programs (also referred to as mobile integrated healthcare). The programs use credentialed EMS personnel to assess and monitor patients that local healthcare providers (EMS agencies or healthcare organizations) have previously identified as a concern. The proposed

rules will facilitate the voluntary formation and implementation of community paramedic programs statewide.

A “on size fits all” approach is not conducive to a successful community paramedic program. Therefore, the proposed rules provide only a broad definition of CP/MIH programs and the rules do not specify programmatic requirements for such programs. Each county, community, or healthcare organization will have different needs. Some may focus the mental health patients (which may include transport to an alternate facility rather than an emergency department). Other EMS agencies may focus on patients that repeatedly request EMS within a specified time period. Healthcare organizations may focus on chronic disease patients after discharge to reduce the readmission rates. Every community is different, the most important component of program development is focusing on the specific needs of the population served and designing a program around them.

The current rules provide sound guidance for the 911 EMS system in each county. The OEMS has a strong history of providing appropriate regulatory oversight and supporting the EMS Systems in North Carolina. The EMS systems are composed of dispatch centers, first responders, ambulance transport agencies, educational programs, and medical oversight. All of these components work well to provide appropriate emergency medical care to the patients who need transport to the emergency department.

However, evaluating the need for a CP/MIH program may involve EMS credentialed personnel operating outside of the 911 System setting. The proposed rule changes more explicitly address credentialed EMS personnel functioning under a medical director in a setting other than the 911 System to provide greater flexibility and to expand this EMS practice setting capacity beyond the local government 911 System.

Summary of Community Paramedic Related Revisions

Rule .0102 – Definitions are being amended to clarify Alternative Practice Setting, Medical Director and Medical Oversight for practice settings. Definitions for Community Paramedicine and Mobile Integrated Healthcare have been added. Grammatical and technical changes are being updated as well.

The definition of “Alternative Practice Setting” is being amended to remove practice restrictions of “a clinical environment.” This simplifies the Alternative Practice Setting as any setting that may not be affiliated with an EMS System. “Community Paramedicine” is being added to clarify the program as a practice setting under the EMS System. Definitions for “Medical Director” and “Medical Oversight” have been updated to reflect general practice settings. “Mobile Integrated Healthcare” was added as it is a nationally used term synonymous with community paramedicine.

Rule .0505 – Scope of Practice for EMS Personnel – is being amended as a technical change to more accurately reflect the expansion of practice settings. This change does not restrict the ability of credentialed EMS personnel function only when affiliated with an EMS System.

Rule .0506 – Practice Settings for EMS Personnel – is being amended to add CP/MIH programs as a practice setting. Refer to the previous discussion in the Overview and in Rule .0102 for details of this setting.

Existing Research on the Effectiveness and Efficiency of CP/MIH Programs

National EMS journals and other publications have documented numerous articles of various programs, how they were established, the criteria for the program, and local successes based on patient outcomes.^{vi} The OEMS has worked with agencies to conduct pilot programs. During the past several years, North Carolina agencies have shared information presented and discussed at conference meetings hosted by the North Carolina Association of EMS Administrators.

To determine whether the benefits of any individual CP/MIH program exceeds the costs, three main questions must be answered:

1. How many emergency department visits are avoided as a result of the program?
2. Does the avoided cost of transport and treatment in the emergency room exceed the cost of operating the community paramedicine program plus any alternative treatment?
3. What is the difference in patient outcomes attributable to the program?

While observational data on patient outcomes and emergency department usage trends is promising,^{vii} the effectiveness and efficiency of CP/MIH programs cannot be determined from the existing case studies. Thus far, program implementation designs do not allow researchers to separate the effect of the program on emergency department use and patient outcomes from other factors. Therefore, the number of avoided emergency department visits and improvements in patient outcomes attributable to the program is unknown. Comprehensive data on program cost and treatment costs are not available.

Furthermore, each CP/MIH program is unique. Individual programs differ in their target populations, interventions, and outcomes. Therefore, it is not possible to assess CP/MIH programs as a whole. North Carolina's three unique pilot programs are summarized below.

Characteristics of North Carolina's Community Paramedic Pilot Programs

The North Carolina General Assembly allocated \$350,000 in 2015 to fund a Community Paramedicine Pilot Program. Session Law 2015-241 Section 12A.12 allowed the Department of Health and Human Services to establish up to three program sites. The three sites selected (on defined) are diverse and reflect the eastern, central, and western geographic areas of the state. McDowell County is a mostly rural, county based EMS system. Wake County is a large metropolitan, county based EMS system. New Hanover County is a medium metropolitan, hospital based EMS system. A report of the Pilot Programs to the Joint Legislative Oversight Committee on Health and Human Services and Fiscal Research Division yielded the following information.

McDowell County EMS

McDowell County's program has 2.5 Full Time Equivalent community paramedic positions which focused on 230 patients which were identified as high volume EMS and Emergency Department uses during a seven month period. Over the course of the pilot, these targeted individuals were

served by the program 125 times. It is unclear how many of these encounters actually prevented emergency department visits; it is not possible to determine whether the individuals would have visited the emergency department in the absence of the program.

Although the total avoided emergency department visit costs cannot be determined, a conservative estimate of the average cost of a single ambulance transport and emergency department visit is \$823. This estimate is based on the average reimbursement rate for the ambulance transport and the lowest acuity patient in the Emergency Department for all payor types.

McDowell County's figures were only based on average reimbursement rates for EMS transports for each payment type. This was combined with the average lowest acuity reimbursed rate for the Emergency Department. The reality is that the cost of providing the service usually exceeds the "average" reimbursement rates for EMS and the Emergency Department.

New Hanover Regional EMS

New Hanover Regional EMS is a hospital based agency utilizing 5 FTE paramedics for their community paramedic program, serving multiple counties. New Hanover began their program after reviewing data which revealed that 10 patients accounted for over 700 "non-emergency" responses in a one year period. The program focuses on three main patient groups; high risk readmissions, high utilizers of the healthcare system, and readmission of ACO patients participating in a Medicare Shared Savings Plan.

The program performed 3,055 patient visits and assisted 824 new patients in FY 2016 to lower readmissions. Readmission rates for high risk patients in the program were 5% less than the hospital average. All patients enrolled in the program were 7% less than the hospital rate. The program also enrolled 20 of the highest EMS and Emergency Department utilizers. Over the course of one year, New Hanover observed a 27% reduction in their top users' transports. The community paramedic program documented a decreased in expenses of \$558,000 for these utilizers, including EMS transports, ED visits, and inpatient hospitalizations. The median decreased charge per patient was \$78,625. It is not possible to determine from the case study how much of this change is attributable to the program intervention or other factors.

Wake County EMS

Wake County EMS (Raleigh) is a county based system utilizing 14 FTEs staffing 5 units across the county for their community paramedic program. Wake identifies these as Advanced Practice Paramedics (APP). These personnel also respond to high acuity 911 calls in the Wake system. The program partners with hospitals and healthcare systems in managing high utilizers, congestive heart failure, and other transitional care patients to reduce operational burdens and costs of care. As part of the 911 system, the program also evaluates patients for acute mental health or substance abuse crises. Medically approved screening criteria may be utilized to redirect patients to the primary psychiatric or substance abuse facility rather than the emergency department.

During an eleven month period the program evaluated a total of 1,191 mental health and acute substance use patients. Nearly half (47%) were provided appropriate services in the home or in non-emergency department settings. It is not possible to determine whether, in the absence of the

program, those individuals would have visited the emergency department. Wake County did not have financial impact information listed in the report.

The program also partnered with Community Care of Wake and Johnston County to provide gap coverage for congestive heart failure and transitional patients recently discharged. The Wake County APP assisted 57 patients by conducting 169 home visits. Financial data was only provided for 8 of the patients.

Over the course of ten months, Community Care documented reductions in inpatient cost to Medicaid (62% reduction of \$31,179) and ED costs to Medicaid (75% reduction of \$19,090). 50% of the patients had no hospitalizations one year after enrolling in the program. It is not possible to determine how much of this change over time is attributable to the program intervention or other factors.

Economic Impact of Implementing CP/MIH Programs in North Carolina

Since this is an optional program and defined locally, impact costs and benefits are unique for each program. OEMS expects at least 8 programs to be initiated or expanded in the near future. OEMS cannot predict how many of the numerous hospital systems and 101 EMS systems may eventually choose to implement a CP/MIH program.

Cost components of the programs could include development of processes (referrals, care plans, monitoring, transition of patients to other care agency or out of the program, obtaining assistance from other agencies), additional positions, additional education or training requirements, potential clinical hours, and any additional equipment (medical equipment, communications, or vehicles). Due to the diversity of individual programs, it is not possible to estimate costs for most program components. The minimum financial impact would be personnel and education hours, estimated at an average of \$22 per hour (\$45,760 per year) for a paramedic.^{viii} Reimbursement rates negotiated between DMH/DD/SA and OEMS for using alternative destinations for behavioral and substance abuse patients can be used for comparison purposes as a rough estimate of the per-encounter operational costs of a CP/MIH program. DMH/DD/SA reimbursement rates ranged from \$164 to \$211 per patient, depending on whether the patient was transported to an alternative destination or treated by EMS in-home but not transported. Note that CP/MIH program costs can be highly variable, depending on the target population and the services provided.

The proposed rules expand the allowable EMS practice settings. If CP/MIH programs become reimbursable in the future and many hospital systems adopt CP/MIH programs, this could create competition between local EMS systems and hospital systems for EMS-credentialed employees.

As seen in these three programs, some personnel do only CP/MIH duties, others still provide 911 services and perform as community paramedics. In order to promote more cost efficiency, the OEMS has not set specific educational requirements for CP/MIH programs. Because the programs are so diverse, the program medical director is responsible for training and education in order to best meet the program needs. These rules provide flexibility for the needs of any program, but also insure that appropriate medical oversight is provided and EMS credentialed personnel must function within the scope of practice as defined by the North Carolina Medical Board.

The benefits are especially challenging to quantify for these programs given the unique nature of each individual program and the limitations of the research literature on the effectiveness of these programs. The three programs in the pilot program suggest not only savings/cost avoidance, but better patient outcomes. Benefits could include improved patient outcomes, reduced medical care costs for the private and public sector, more ambulances available for other calls, potentially decrease ambulance holding times in emergency departments, and reduce emergency department congestion. While many of these benefits are case-specific and unquantifiable, North Carolina's pilot program data provide a rough estimate of the magnitude of the potential benefits of avoided ED utilization on a per-unit basis:

- Cost estimates from the North Carolina Division of Medical Assistance used the lowest Medicaid reimbursement rate for ambulance transport and emergency department visit. The range was \$354 - \$507 per avoided transport and emergency department visit combined.
- A 2013 study funded by the National Institute of Health, and published by the Public Library of Science, found that the median charge for the ten most common outpatient conditions in the emergency department was \$1,233.^{ix}
- DMA provided NCOEMS with the actual amount paid for three common ED outpatient diagnoses, for the three pilot counties used in this grant (McDowell, New Hanover, and Wake). These three (congestive heart failure, pneumonia, and diabetes) are just a small sample of what is seen in the emergency department. The average amount paid for those three diagnoses, in the three pilot counties is \$189.16.

Analysis: Hospital Definition (Trauma Related) Revisions and its Anticipated Impact

Rule .0102 – Definitions are being amended to include federal facilities to the hospital definition. Womack Army Medical Center and Naval Medical Center Camp Lejeune are not licensed by the North Carolina Department of Health and Human Services. Administrators from these facilities have communicated an interest in pursuing state Trauma Center Designation from the OEMS.

The American College of Surgeons (ACS) and the U.S. Department of Defense Military Health Systems (MHS) have formed a partnership to improve educational opportunities, systems-based practices, and research capabilities to advance high quality, cost-effective care for surgical patients. The ACS is taking the lead role in a national effort to join the nation’s military and civilian trauma systems into one composite national trauma system. This change will strengthen North Carolina’s partnership with these federal facilities and ultimately provide a higher standard of trauma care for these patients in a closer proximity to the citizens they serve. Studies have shown injured patients treated at designated trauma centers have better outcomes than other hospitals.^x

Since Trauma Center designation is optional, applications for either of these federal facilities would be processed as any other new application. The estimated time for a program manager processing a new trauma center applications is approximately 8 hours. Coordinating the site visit by clerical staff is estimated at approximately 24 hours. Site visits and designation renewals occur every 4 years.

Salary Grade to Represent Comparable Position	Average Annual Compensation	Cost/Hr.
Management level positions (sg 76-78)	~102,000	~\$49
Clerical level positions (sg 59- 61)	~\$47,850	~\$23

References to OEMS staff hourly salaries are an average for each salary range grade based on the position levels including fringe currently budgeted for agency employees

Application Review – Manager	~\$392
Coordination of Site Visit – Clerical	~\$552

The facility must function at a trauma service corresponding to the respective level applied for and include submission of trauma data for twelve months prior to the designation as defined in Rules .0901 Trauma Center Criteria and .0904 Initial Designation Process. The facility seeking designation would have to comply with specific positions to include a trauma program manager and trauma registrar. The average trauma program manager and trauma register costs are based upon salary estimates from different North Carolina locations.^{xi} The initial purchase for the North Carolina Trauma Registry software program, provided through Digital Innovation, Inc., as well as the estimated annual maintenance contract agreement is estimated below.

Trauma Program Manager Salary with Benefits	~\$160,800	~\$77 hr
Trauma Registrar Salary with Benefits	~\$68,500	~\$33 hr
Digital Innovation, Inc. initial software purchase (5 users)		~\$15,000
Digital Innovation, Inc. annual maintenance agreement		~\$5,000

OEMS assumes the initial request for designation will be as a Level III Trauma Center. The site team for a Level III initial visit is defined in Rule .0904. These include one trauma surgeon (defined), one emergency physician (defined), and one trauma program manager (defined). The OEMS contracts with individual team members and the facility requesting designation is billed for the team’s time, travel, and lodging. Costs typically vary due to locations of team members. Average site visit costs range between \$3500 and \$5000.

Approximately 12 hours of OEMS manager-level staff time is devoted to each site visit at a cost of \$588. Costs to OEMS staff serving as site visit team members are not passed on to the facility

Impact Summary

Year 1 Economic Impacts	Costs	Benefits
Federal Government	~\$254,300	
State Government	~\$6,532	5,000
Local Government		
Private Entities	Revenue shifting between service facilities (unquantified)	Better trauma care for local residents (unquantified)
Total	~\$260,832	5,000

Analysis: EMS System Requirements

Rule .0201 – Section (13)(G) is being amended to provide EMS Systems the ability to have more clear oversight of coverage provided for the public at mass gathering. This change clarifies how and which EMS credentialed personnel will provide coverage to the public-at-large at such events. Local EMS System officials and the Medical Director determine the appropriate EMS coverage for the mass gathering events to insure the care provided is compliant with local medical oversight protocols and practices. These plans are not reviewed by OEMS and are kept locally.

Impact

County Government Employees

Position	Average Annual Compensation (plus 20% benefits)	Cost/Hr
Assistant Director of EMS	~\$70,069	~\$33

These positions are classified in the *University of North Carolina School of Government “County Salaries in North Carolina 2017”* <http://www.sog.unc.edu/publications/reports/county-salaries-north-carolina-2017>

OEMS estimates a maximum of two hours to update the mass gathering plan and would be completed by an assistant chief or director of the agency. The plan does not require review by OEMS, but it must be available if requested. There are 101 EMS Systems in North Carolina.

Federal Government	~\$6,666
State Government	\$0
Local Government	\$0
Private Entities	<u>Unquantified benefits from appropriate EMS coverage</u>
Total	~\$6,666

Conclusion

Community Paramedicine and Mobile Integrated Healthcare are synonymous terms for the nationwide growth of broader EMS services’ efforts to reduce repeat users of ambulance response/transport, reduce unnecessary emergency department visits, coordinating multiple services to insure better patient outcomes, and reducing hospital readmission rates. The OEMS has defined these programs to allow local communities and healthcare organizations to establish “customized” programs to meet the local needs. The “Community Paramedic Pilot Programs” report has documented the successes of several those programs, well enough that the Legislature has approved the grant funding for another year.

The expansion of practice settings to include CP/MIH programs further opens the door to career options for EMS personnel other than the 911 EMS provider setting. The setting may also serve to push the EMS profession towards future licensure and recognition as an “allied health” provider.

Every effort has been made to minimize any financial burden that may be associated with compliance with these proposed rules. The primary building block for the programs centers on the medical oversight. The Medical Director defines the plan of care, insures the scope of practice, and guides the multidisciplinary team to insure quality patient-centered care. The CP/MIH programs strive to avoid costly repetitive transports, emergency department visits, and readmissions to facilities.

An unfortunate reality is that EMS reimbursement is based on transport. The success of these programs results in fewer transports and unnecessary emergency department visits. The dilemma facing EMS organizations is doing what is best for the patient, but the cost is lost reimbursement. Currently, CP/MIH programs are not eligible for reimbursement. However, expansion of the programs may create a larger base to push for reimbursement in the future. Until then, agencies will continue to absorb the costs, but also compile valuable data on patient outcomes. OEMS is optimistic that increasing data will continue to validate better patient outcomes and cost savings (specifically impacts on the emergency departments). This data will be vital in the efforts to achieve future reimbursement for the CP/MIH programs. The OEMS will continue to partner with EMS providers, other stakeholders, and the Division of Medical Assistance to seek new alternatives for funding for these programs.

Amending the “Hospital” definition to include the federal military facilities allows the opportunity for those facilities to enhance their relationship and influence with the surrounding communities. The American College of Surgeon is also a driving force for civilian and military collaboration for trauma. If they choose to seek state trauma center designation, the rapport and support from these

facilities will further strengthen available state resources related to trauma and disaster management.

The impact of the proposed rule change is likely to be substantial but is unquantified; however, there is reason to believe the impact would be substantial. Overall, OEMS believes that the effect of incorporating these changes will benefit the quality of care and safety provided to the citizens of North Carolina.

Alternatives

OEMS could mandate and define a one-size-fits-all paramedicine program. Mandated programs would require specific outcome goals, operational criteria, education, and monitoring. Establishing an education program criteria would add significant cost to OEMS to develop the content as well as to each local program. The top down directive would further burden the local EMS with compliance for a program that may not even meet their local community needs. Mandating a program would be costly, ineffective, and potentially adversely impact patient outcomes. Local systems/agencies conducting gap analysis of their community to build a program is vital for success.

OEMS could also mandate that any paramedicine program or alternative practice setting must function under the system and system medical oversight. This may place undue burden on the county government that may not want to participate in or take the risk for personnel working in a setting other than the 911 system. Why require a system medical director and the county to be responsible for EMS credentialed personnel working in a hospital emergency department or a hospital based mobile integrated healthcare program working with discharged patients. Tying these practice setting to the EMS system prohibits free enterprise. The EMS Systems are designed to meet the community's emergency response needs. These changes allow credentialed EMS personnel to progress into more of an allied health professional status. These rules allow such flexibility.

Endnotes

- ⁱ A total of 17,763 patients met the definition of a high utilizer in NC for calendar year 2015 according to OEMS analysis of hospital records. These patients accounted for a total of 141,176 EMS calls for service and were transported to the ED a total of 103,221 times. See Appendix B.
- NC DHHS, (March 2017). “Community Paramedicine Pilot Program: Report to the Joint Legislative Oversight Committee on Health and Human Services and Fiscal Research Division.”
- Agency for Healthcare Research and Quality (USDHHS) (2014). Specially Trained Paramedics Respond to Nonemergency 911 Calls and Proactively Care for Frequent Callers, Reducing Inappropriate Use of Emergency Service. Accessed at innovations.ahrq.gov/profiles/specially-trained-paramedics-respond-nonemergency-911-calls-and-proactively-care-frequent
- ⁱⁱ Tang N, Stein J, Hsia RY, Maselli JH, Gonzales R. (2010). Trends and Characteristics of US Emergency Department Visits, 1997-2007. *JAMA*;304(6):664–670. Accessed at: <https://jamanetwork.com/journals/jama/fullarticle/186383>
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- ⁱⁱⁱ Murawski, John (2017). Wake County EMS has one solution to overcrowded emergency rooms. *Raleigh News and Observer*. Accessed at <http://www.newsobserver.com/news/local/counties/wake-county/article14433806.html>
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- ^{iv} CMS (2016). Readmissions Reduction Program (HRRP). <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html>;
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- ^v Soril LJ et al (2016). Characteristics of frequent users of the emergency department in the general adult population: A systematic review of international healthcare systems. *Health Policy*: 120(5). Accessed at: <https://www.ncbi.nlm.nih.gov/pubmed/26947060>
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- ^{vi} National Association of Emergency Medical Technicians (2015). “Mobile Integrated Healthcare and Community Paramedicine (MIH-CP),” Accessible at <https://www.naemt.org/docs/default-source/MIH-CP/naemt-mih-cp-report.pdf>
- ^{vii} *Ibid*;
- Bryan Y. Choi et al, (2016). “Mobile Integrated Health Care and Community Paramedicine: An Emerging Emergency Medical Services Concept”, In *Annals of Emergency Medicine*, Volume 67, Issue 3. <https://doi.org/10.1016/j.annemergmed.2015.06.005>;
- AHRQ (2016). New Care and Referral Pathways for Nonemergent 911 Callers and At-Risk Patients Reduce Emergency Department Visits and Readmissions, Generate Substantial Cost Savings.

<https://innovations.ahrq.gov/profiles/new-care-and-referral-pathways-nonemergent-911-callers-and-risk-patients-reduce-emergency>

- ^{viii} Average annual salary reported by UNC plus 20% benefits, assuming a work schedule of 2080 hours per year. *University of North Carolina School of Government “County Salaries in North Carolina 2017”* <http://www.sog.unc.edu/publications/reports/county-salaries-north-carolina-2017>
- ^{ix} Caldwell N, Srebotnjak T, Wang T, Hsia R (2013) “How Much Will I Get Charged for This?” Patient Charges for Top Ten Diagnoses in the Emergency Department. *PLOS ONE* 8(2): e55491. doi: 10.1371/journal.pone.0055491
- ^x Bowman, S. M., Zimmerman, F. J., Sharar, S. R., Baker, M. W. and Martin, D. P. (2008), Rural Trauma: Is Trauma Designation Associated With Better Hospital Outcomes?. *The Journal of Rural Health*, 24: 263–268. doi:10.1111/j.1748-0361.2008.00167.x
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- ^{xi} Payscale.com was used to determine base salaries for the positions in North Carolina. The benefits for a private sector hospital worker, based on national data from the Bureau of Labor Statistics’ Employer Cost for Employee Compensation series for the Hospitals sector, was valued at 52% of base salaries in the second quarter of 2017 (<https://www.bls.gov/iag/tgs/iag622.htm>).

10A NCAC 13P .0102 is proposed for amendment as follows:

10A NCAC 13P .0102 DEFINITIONS

In addition to the definitions in G.S. 131E-155, the following definitions apply throughout this Subchapter:

- (1) "Affiliated EMS Provider" means the firm, corporation, agency, organization, or association identified ~~to~~ with a specific county EMS system as a condition for EMS Provider Licensing as required by Rule ~~.0204(b)(1)~~ .0204 of this Subchapter.
- (2) "Affiliated Hospital" means a non-trauma center hospital that is owned by the Trauma Center or there is a contract or other agreement to allow for the acceptance or transfer of the Trauma Center's patient population to the non-trauma center hospital.
- (3) "Affiliate" or "Affiliation" means a reciprocal agreement and association that includes active participation, collaboration, and involvement in a process or system between two or more parties.
- (4) "Alternative Practice Setting" means ~~a clinical environment~~ a practice setting that utilizes credentialed EMS personnel that may not be affiliated with or under the oversight of ~~the~~ an EMS System or EMS System Medical Director.
- (5) "Air Medical Ambulance" means an aircraft configured and medically equipped to transport patients by air. The patient care compartment of air medical ambulances shall be staffed by medical crew members approved for the mission by the Medical Director.
- (6) "Air Medical Program" means a SCTP or EMS System utilizing rotary-wing or fixed-wing aircraft configured and operated to transport patients.
- (7) "Assistant Medical Director" means a physician, EMS-PA, or EMS-NP who assists the Medical Director with the medical aspects of the management of an EMS System or SCTP.
- (8) "Bypass" means a decision made by the patient care technician to transport a patient from the scene of an accident or medical emergency past a receiving facility for the purposes of accessing a facility with a higher level of care, or a hospital of its own volition reroutes a patient from the scene of an accident or medical emergency or referring hospital to a facility with a higher level of care.
- (9) "Community Paramedicine" means an EMS System utilizing credentialed personnel who have received additional training as determined by the EMS system Medical Director to provide knowledge and skills for the community needs beyond the 911 emergency response and transport operating guidelines defined in the EMS system plan.
- ~~(9)~~ (10) "Contingencies" mean conditions placed on a designation that, if unmet, may result in the loss or amendment of a designation.
- ~~(10)~~ (11) "Convalescent Ambulance" means an ambulance used on a scheduled basis solely to transport patients having a known non-emergency medical condition. Convalescent ambulances shall not be used in place of any other category of ambulance defined in this Subchapter.
- ~~(11)~~ (12) "Deficiency" means the failure to meet essential criteria for a designation that can serve as the basis for a focused review or denial of a designation.
- ~~(12)~~ (13) "Department" means the North Carolina Department of Health and Human Services.
- ~~(13)~~ (14) "Diversion" means the hospital is unable to accept a patient due to a lack of staffing or resources.

- ~~(14)~~ (15) "Educational Medical Advisor" means the physician responsible for overseeing the medical aspects of approved EMS educational programs.
- ~~(15)~~ (16) "EMS Care" means all services provided within each EMS System by its affiliated EMS agencies and personnel that relate to the dispatch, response, treatment, and disposition of any patient.
- ~~(16)~~ (17) "EMS Educational Institution" means any agency credentialed by the OEMS to offer EMS educational programs.
- ~~(17)~~ (18) "EMS Non-Transporting Vehicle" means a motor vehicle operated by a licensed EMS provider dedicated and equipped to move medical equipment and EMS personnel functioning within the scope of practice of an AEMT or Paramedic to the scene of a request for assistance. EMS nontransporting vehicles shall not be used for the transportation of patients on the streets, highways, waterways, or airways of the state.
- ~~(18)~~ (19) "EMS Peer Review Committee" means a committee as defined in G.S. 131E-155(6b).
- ~~(19)~~ (20) "EMS Performance Improvement Self-Tracking and Assessment of Targeted Statistics" means one or more reports generated from the State EMS data system analyzing the EMS service delivery, personnel performance, and patient care provided by an EMS system and its associated EMS agencies and personnel. Each EMS Performance Improvement Self-Tracking and Assessment of Targeted Statistics focuses on a topic of care such as trauma, cardiac arrest, EMS response times, stroke, STEMI (heart attack), and pediatric care.
- ~~(20)~~ (21) "EMS Provider" means those entities defined in G.S. 131E-155(13a) that hold a current license issued by the Department pursuant to G.S. 131E-155.1.
- ~~(21)~~ (22) "EMS System" means a coordinated arrangement of local resources under the authority of the county government (including all agencies, personnel, equipment, and facilities) organized to respond to medical emergencies and integrated with other health care providers and networks including public health, community health monitoring activities, and special needs populations.
- ~~(22)~~ (23) "Essential Criteria" means those items that are the requirements for the respective level of trauma center designation (I, II, or III), as set forth in Rule .0901 of this Subchapter.
- ~~(23)~~ (24) "Focused Review" means an evaluation by the OEMS of corrective actions to remove contingencies that are a result of deficiencies following a site visit.
- ~~(24)~~ (25) "Ground Ambulance" means an ambulance used to transport patients with traumatic or medical conditions or patients for whom the need for specialty ~~care care, or emergency~~ emergency, or non-emergency medical care is anticipated either at the patient location or during transport.
- ~~(25)~~ (26) "Hospital" means a licensed facility as defined in G.S. ~~131E-176, 131E-176~~ or an acute care in-patient diagnostic and treatment facility located within the State of North Carolina that is owned and operated by an agency of the United States government.
- ~~(26)~~ (27) "Immediately Available" means the physical presence of the health professional or the hospital resource within the trauma center to evaluate and care for the trauma patient.

- ~~(27)~~ (28) "Inclusive Trauma System" means an organized, multi-disciplinary, evidence-based approach to provide quality care and to improve measurable outcomes for all defined injured patients. EMS, hospitals, other health systems, and clinicians shall participate in a structured manner through leadership, advocacy, injury prevention, education, clinical care, performance improvement, and research resulting in integrated trauma care.
- ~~(28)~~ (29) "Infectious Disease Control Policy" means a written policy describing how the EMS system will protect and prevent its patients and EMS professionals from exposure and illness associated with contagions and infectious disease.
- ~~(29)~~ (30) "Lead RAC Agency" means the agency (comprised of one or more Level I or II trauma centers) that provides staff support and serves as the coordinating entity for trauma planning.
- ~~(30)~~ (31) "Level I Trauma Center" means a hospital that has the capability of providing guidance, research, and total care for every aspect of injury from prevention to rehabilitation.
- ~~(31)~~ (32) "Level II Trauma Center" means a hospital that provides trauma care regardless of the severity of the ~~injury~~ injury, but may lack the comprehensive care as a Level I trauma ~~center~~ center, and does not have trauma research as a primary objective.
- ~~(32)~~ (33) "Level III Trauma Center" means a hospital that provides assessment, resuscitation, emergency operations, and stabilization, and arranges for hospital transfer as needed to a Level I or II trauma center.
- ~~(33)~~ (34) "Licensed Health Care Facility" means any health care facility or hospital licensed by the Department of Health and Human Services, Division of Health Service Regulation.
- ~~(34)~~ (35) "Medical Crew Member" means EMS personnel or other health care professionals who are licensed or registered in North Carolina and are affiliated with a SCTP.
- ~~(35)~~ (36) "Medical Director" means the physician responsible for the medical aspects of the management of ~~an EMS System, Alternative Practice Setting, SCTP, a practice setting utilizing credentialed EMS personnel or medical crew members,~~ or a Trauma Center.
- ~~(36)~~ (37) "Medical Oversight" means the responsibility for the management and accountability of the medical care aspects of ~~an EMS System, Alternative Practice Setting, or SCTP;~~ a practice setting utilizing credentialed EMS personnel or medical crew members. Medical Oversight includes physician direction of the initial education and continuing education of EMS personnel or medical crew members; development and monitoring of both operational and treatment protocols; evaluation of the medical care rendered by EMS personnel or medical crew members; participation in system or program evaluation; and directing, by two-way voice communications, the medical care rendered by the EMS personnel or medical crew members.
- (38) "Mobile Integrated Healthcare" means utilizing credentialed personnel who have received additional training as determined by the Alternative Practice Setting medical director to provide knowledge and skills for the healthcare provider program needs.

- ~~(37)~~ (39) "Off-line Medical Control" means medical supervision provided through the EMS System Medical Director or SCTP Medical Director who is responsible for the day-to-day medical care provided by EMS personnel. This includes EMS personnel education, protocol development, quality management, peer review activities, and EMS administrative responsibilities related to assurance of quality medical care.
- ~~(38)~~ (40) "Office of Emergency Medical Services" means a section of the Division of Health Service Regulation of the North Carolina Department of Health and Human Services located at 1201 Umstead Drive, Raleigh, North Carolina 27603.
- ~~(39)~~ (41) "On-line Medical Control" means the medical supervision or oversight provided to EMS personnel through direct communication in-person, via radio, cellular phone, or other communication device during the time the patient is under the care of an EMS professional.
- ~~(40)~~ (42) "Operational Protocols" means the administrative policies and procedures of an EMS System or that provide guidance for the day-to-day operation of the system.
- ~~(41)~~ (43) "Participating Hospital" means a hospital that supplements care within a larger trauma system by the initial evaluation and assessment of injured patients for transfer to a designated trauma center if needed.
- ~~(42)~~ (44) "Physician" means a medical or osteopathic doctor licensed by the North Carolina Medical Board to practice medicine in the state of North Carolina.
- ~~(43)~~ (45) "Regional Advisory Committee" means a committee comprised of a lead RAC agency and a group representing trauma care providers and the community, for the purpose of regional ~~trauma~~ planning, establishing, and maintaining a coordinated trauma system.
- ~~(44)~~ (46) "Request for Proposal" means a State document that must be completed by each hospital seeking initial or renewal trauma center designation.
- ~~(45)~~ (47) "Significant Failure to Comply" means a degree of non-compliance determined by the OEMS during compliance monitoring to exceed the ability of the local EMS System to correct, warranting enforcement action pursuant to Section .1500 of this Subchapter.
- ~~(46)~~ (48) "State Medical Asset and Resource Tracking Tool" means the Internet web-based program used by the OEMS both ~~daily~~ in its daily operations and during times of disaster to identify, ~~record~~ record, and monitor EMS, hospital, health ~~care~~ care, and sheltering resources statewide, including facilities, personnel, vehicles, equipment, and pharmaceutical and supply caches.
- ~~(47)~~ (49) "Specialty Care Transport Program" means a program designed and operated for the transportation of a patient by ground or air requiring specialized interventions, ~~monitoring~~ monitoring, and staffing by a paramedic who has received additional training as determined by the program Medical Director beyond the minimum training prescribed by the OEMS, or by one or more other healthcare professional(s) qualified for the provision of specialized care based on the patient's condition.

- ~~(48)~~ (50) "Specialty Care Transport Program Continuing Education Coordinator" means a Level I EMS Instructor within a SCTP who is responsible for the coordination of EMS continuing education programs for EMS personnel within the program.
- ~~(49)~~ (51) "Stretcher" means any wheeled or portable device capable of transporting a person in a recumbent position and may only be used in an ambulance vehicle permitted by the Department.
- ~~(50)~~ (52) "Stroke" means an acute cerebrovascular hemorrhage or occlusion resulting in a neurologic deficit.
- ~~(51)~~ (53) "System Continuing Education Coordinator" means the Level I EMS Instructor designated by the local EMS System who is responsible for the coordination of EMS continuing education programs.
- ~~(52)~~ (54) "System Data" means all information required for daily electronic submission to the OEMS by all EMS Systems using the EMS data set, data dictionary, and file format as specified in "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," incorporated herein by reference including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost and online at www.ncems.org at no cost.
- ~~(53)~~ (55) "Trauma Center" means a hospital designated by the State of North Carolina and distinguished by its ability to manage, on a 24-hour basis, the severely injured patient or those at risk for severe injury.
- ~~(54)~~ (56) "Trauma Center Criteria" means essential criteria to define Level I, II, or III trauma centers.
- ~~(55)~~ (57) "Trauma Center Designation" means a process of approval in which a hospital voluntarily seeks to have its trauma care capabilities and performance evaluated by experienced on-site reviewers.
- ~~(56)~~ (58) "Trauma Diversion" means a trauma center of its own volition declines to accept an acutely injured patient due to a lack of staffing or resources.
- ~~(57)~~ (59) "Trauma Guidelines" mean standards for practice in a variety of situations within the trauma system.
- ~~(58)~~ (60) "Trauma Minimum Data Set" means the basic data required of all hospitals for submission to the Trauma Registry.
- ~~(59)~~ (61) "Trauma Patient" means any patient with an ICD-CM discharge diagnosis as defined in the "North Carolina Trauma Registry Data Dictionary," incorporated herein by reference in accordance with G.S.150B-21.6, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost and online at <https://www.ncdhhs.gov/dhsr/EMS/trauma/traumaregistry.html> at no cost.
- ~~(60)~~ (62) "Trauma Program" means an administrative entity that includes the trauma service and coordinates other trauma-related activities. It shall also include the trauma Medical Director, trauma program manager/trauma coordinator, and trauma registrar. This program's reporting structure shall give it the ability to interact with at least equal authority with other departments in the hospital providing patient care.
- ~~(61)~~ (63) "Trauma Registry" means a disease-specific data collection composed of a file of uniform data elements that describe the injury event, demographics, pre-hospital information, diagnosis, care,

outcomes, and costs of treatment for injured patients collected and electronically submitted as defined by the OEMS. The elements of the Trauma Registry can be accessed at <https://www.ncdhhs.gov/dhsr/EMS/trauma/traumaregistry.html> at no cost.

- ~~(62)~~ (64) "Treatment Protocols" means a document approved by the Medical Directors of the local EMS System, Specialty Care Transport Program, Alternative Practice Setting, or Trauma Center and the OEMS specifying the diagnostic procedures, treatment procedures, medication administration, and patient-care-related policies that shall be completed by EMS personnel or medical crew members based upon the assessment of a patient.
- ~~(63)~~ (65) "Triage" means the assessment and categorization of a patient to determine the level of EMS and healthcare facility based care required.
- ~~(64)~~ (66) "Water Ambulance" means a watercraft specifically configured and medically equipped to transport patients.

History Note: Authority G.S. 131E-155(6b); 131E-162; 143-508(b), 143-508(d)(1); 143-508(d)(2); 143-508(d)(3); 143-508(d)(4); 143-508(d)(5); 143-508(d)(6); 143-508(d)(7); 143-508(d)(8); 143-508(d)(13); 143-518(a)(5);
 Temporary Adoption Eff. January 1, 2002;
 Eff. April 1, 2003;
 Amended Eff. March 3, 2009 pursuant to E.O. 9, Beverly Perdue, March 3, 2009;
 Pursuant to G.S. 150B-21.3(c), a bill was not ratified by the General Assembly to disapprove this rule;
 Readopted Eff. January 1, ~~2017~~ 2017;
 Amended Eff. July 1, 2018.

10A NCAC 13P .0201 is proposed for amendment as follows:

10A NCAC 13P .0201 EMS SYSTEM REQUIREMENTS

(a) County governments shall establish EMS Systems. Each EMS System shall have:

- (1) a defined geographical service area for the EMS System. The minimum service area for an EMS System shall be one county. There may be multiple EMS Provider service areas within an EMS System. The highest level of care offered within any EMS Provider service area shall be available to the citizens within that service area 24 hours a day, seven days a week;
- (2) a defined scope of practice for all EMS personnel functioning in the EMS System within the parameters set forth by the North Carolina Medical Board pursuant to G.S. 143-514;
- (3) written policies and procedures describing the dispatch, coordination, and oversight of all responders that provide EMS care, specialty patient care skills, and procedures as set forth in Rule ~~.0301(a)~~(4) .0301 of this Subchapter, and ambulance transport within the system;
- (4) at least one licensed EMS Provider;
- (5) a listing of permitted ambulances to provide coverage to the service area 24 hours a day, seven days a week;
- (6) personnel credentialed to perform within the scope of practice of the system and to staff the ambulance vehicles as required by G.S. 131E-158. There shall be a written plan for the use of credentialed EMS personnel for all practice settings used within the system;
- (7) written policies and procedures specific to the utilization of the EMS System's EMS Care data for the daily and on-going management of all EMS System resources;
- (8) a written Infectious Disease Control Policy as defined in Rule ~~.0102(28)~~ .0102 of this Subchapter and written procedures that are approved by the EMS System Medical Director that address the cleansing and disinfecting of vehicles and equipment that are used to treat or transport patients;
- (9) a listing of resources that will provide online medical direction for all EMS Providers operating within the EMS System;
- (10) an EMS communication system that provides for:
 - (A) public access to emergency services by dialing 9-1-1 within the public dial telephone network as the primary method for the public to request emergency assistance. This number shall be connected to the PSAP with immediate assistance available such that no caller will be instructed to hang up the telephone and dial another telephone number. A person calling for emergency assistance shall not be required to speak with more than two persons to request emergency medical assistance;
 - (B) a PSAP operated by public safety telecommunicators with training in the management of calls for medical assistance available 24 hours a day, seven days a week;
 - (C) dispatch of the most appropriate emergency medical response unit or units to any caller's request for assistance. The dispatch of all response vehicles shall be in accordance with a written EMS System plan for the management and deployment of response vehicles including requests for mutual aid; and

- (D) two-way radio voice communications from within the defined service area to the PSAP and to facilities where patients are transported. The PSAP shall maintain all required FCC radio licenses or authorizations;
 - (11) written policies and procedures for addressing the use of SCTP and Air Medical Programs resources utilized within the system;
 - (12) a written continuing education program for all credentialed EMS personnel, under the direction of a System Continuing Education Coordinator, developed and modified based on feedback from EMS Care system data, review, and evaluation of patient outcomes and quality management peer reviews, that follows the criteria set forth in Rule .0501 of this Subchapter;
 - (13) written policies and procedures to address management of the EMS System that includes:
 - (A) triage and transport of all acutely ill and injured patients with time-dependent or other specialized care issues including trauma, stroke, STEMI, burn, and pediatric patients that may require the by-pass of other licensed health care facilities and that are based upon the expanded clinical capabilities of the selected healthcare facilities;
 - (B) triage and transport of patients to facilities outside of the system;
 - (C) arrangements for transporting patients to identified facilities when diversion or bypass plans are activated;
 - (D) reporting, monitoring, and establishing standards for system response times using system data;
 - (E) weekly updating of the SMARTT EMS Provider information;
 - (F) a disaster plan;
 - (G) a mass-gathering ~~plan~~; plan that includes how the provision of EMS standby coverage for the public-at-large will be provided;
 - (H) a mass-casualty plan;
 - (I) a weapons plan for any weapon as set forth in Rule .0216 of this Section;
 - (J) a plan on how EMS personnel shall report suspected child abuse pursuant to G.S. 7B-301;
 - (K) a plan on how EMS personnel shall report suspected abuse of the disabled pursuant to G.S. 108A-102; and
 - (L) a plan on how each responding agency is to maintain a current roster of its personnel providing EMS care within the county under the provider number issued pursuant to Paragraph (c) of this Rule, in the OEMS credentialing and information database;
 - (14) affiliation as defined in Rule ~~.0102(3)~~ .0102 of this Subchapter with a trauma RAC as required by Rule .1101(b) of this Subchapter; and
 - (15) medical oversight as required by Section .0400 of this Subchapter.
- (b) Each EMS System that utilizes emergency medical dispatching agencies applying the principles of EMD or offering EMD services, procedures, or programs to the public shall have:
- (1) a defined service area for each agency;

- (2) appropriate personnel within each agency, credentialed in accordance with the requirements set forth in Section .0500 of this Subchapter, to ensure EMD services to the citizens within that service area are available 24 hours per day, seven days a week; and
- (3) EMD responsibilities in special situations, such as disasters, mass-casualty incidents, or situations requiring referral to specialty hotlines.

(c) The EMS System shall obtain provider numbers from the OEMS for each entity that provides EMS Care within the county.

(d) An application to establish an EMS System shall be submitted by the county to the OEMS for review. When the system is comprised of more than one county, only one application shall be submitted. The proposal shall demonstrate that the system meets the requirements in Paragraph (a) of this Rule. System approval shall be granted for a period of six years. Systems shall apply to OEMS for reapproval no more than 90 days prior to expiration.

History Note: Authority G.S. 131E-155(1); 131E-155(6); 131E-155(7); 131E-155(8); 131E-155(9); 131E-155(13a); 131E-155(15); 143-508(b); 143-508(d)(1); 143-508(d)(2); 143-508(d)(3); 143-508(d)(5); 143-508(d)(8); 143-508(d)(9); 143-508(d)(10); 143-508(d)(13); 143-517; 143-518; Temporary Adoption Eff. January 1, 2002; Eff. August 1, 2004; Amended Eff. January 1, 2009; Readopted Eff. January 1, ~~2017~~ 2017; Amended Eff. July 1, 2018.

10A NCAC 13P .0222 is proposed for amendment as follows:

10A NCAC 13P .0222 TRANSPORT OF STRETCHER BOUND PATIENTS

- (a) Any person transported on a stretcher as defined in Rule ~~.0102(49)~~ .0102 of this Subchapter meets the definition of patient as defined in G.S. 131E-155(16).
- (b) Stretchers may only be utilized for patient transport in an ambulance permitted by the OEMS in accordance with G.S. 131E-156 and Rule .0211 of this Section.
- (c) The Medical Care Commission exempts wheeled chair devices used solely for the transportation of mobility impaired persons in non-permitted vehicles from the definition of stretcher.

History Note: Authority G.S. 131E-156; 131E-157; 143-508(d)(8);
Eff. January 1, ~~2017~~ 2017;
Amended Eff. July 1, 2018.

10A NCAC 13P .0301 is proposed for amendment as follows:

10A NCAC 13P .0301 SPECIALTY CARE TRANSPORT PROGRAM CRITERIA

(a) EMS Providers seeking designation to provide specialty care transports shall submit an application for program approval to the OEMS at least 60 days prior to field implementation. The application shall document that the program has:

- (1) a defined service area that identifies the specific transferring and receiving facilities the program is intended to service;
- (2) written policies and procedures implemented for medical oversight meeting the requirements of Section .0400 of this Subchapter;
- (3) ~~Service~~ service available on a 24 hour a day, seven days a week basis;
- (4) the capability to provide the patient care skills and procedures as specified in "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data ~~Collection;~~" Collection";
- (5) a written continuing education program for EMS personnel, under the direction of the Specialty Care Transport Program Continuing Education Coordinator, developed and modified based upon feedback from program data, review and evaluation of patient outcomes, and quality management review that follows the criteria set forth in Rule .0501 of this Subchapter;
- (6) a communication system that provides two-way voice communications for transmission of patient information to medical crew members anywhere in the service area of the program. The SCTP Medical Director shall verify that the communications system is satisfactory for on-line medical direction;
- (7) medical crew members that have completed training conducted every six months regarding:
 - (A) operation of the EMS communications system used in the program; and
 - (B) the medical and patient safety equipment specific to the program;
- (8) written operational protocols for the management of equipment, supplies, and medications. These protocols shall include:
 - (A) a listing of all standard medical equipment, supplies, and medications, approved by the Medical Director as sufficient to manage the anticipated number and severity of injury or illness of the patients, for all vehicles used in the program based on the treatment protocols and approved by the OEMS; and
 - (B) a methodology to ensure that each ground vehicle and aircraft contains the required equipment, supplies, and medications on each response; and
- (9) written policies and procedures specifying how EMS Systems will dispatch and utilize the ground ambulances and aircraft operated by the program.

(b) When transporting patients, staffing for the ground ambulance and aircraft used in the SCTP shall be approved by the SCTP Medical Director as medical crew members, using any of the following as determined by the transferring physician who is responsible for the medical aspects of the mission to manage the anticipated severity of injury or illness of the patient:

- (1) paramedic;
- (2) nurse practitioner;

- (3) physician;
- (4) physician assistant;
- (5) registered nurse; or
- (6) respiratory therapist.

(c) SCTP as defined in Rule ~~0102(47)~~ .0102 of this Subchapter are exempt from the staffing requirements defined in G.S. 131E-158(a).

(d) SCTP approval is valid for a period to coincide with the EMS Provider License that is issued by OEMS and is valid for six years. Programs shall apply to the OEMS for ~~reapproval~~ reapproval no more than 90 days prior to expiration.

History Note: Authority G.S. 131E-155.1(b); 131E-158; 143-508;
Temporary Adoption Eff. January 1, 2002;
Eff. January 1, 2004;
Amended Eff. January 1, 2004;
Amended Eff. March 3, 2009 pursuant to E.O. 9, Beverly Perdue, March 3, 2009;
Pursuant to G.S. 150B-21.3(c), a bill was not ratified by the General Assembly to disapprove this rule;
Readopted Eff. January 1, ~~2017~~ 2017;
Amended Eff. July 1, 2018.

10A NCAC 13P .0505 is proposed for amendment as follows:

10A NCAC 13P .0505 SCOPE OF PRACTICE FOR EMS PERSONNEL

EMS Personnel educated in approved programs, credentialed by the OEMS, and ~~affiliated with an approved EMS System~~ functioning under physician medical oversight may perform acts and administer intravenous fluids and medications as allowed by the North Carolina Medical Board pursuant to G.S. 143-514.

*History Note: Authority G.S. 143-508(d)(6); 143-514;
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2,
~~2016.~~ 2016;
Amended Eff. July 1, 2018.*

10A NCAC 13P .0506 is proposed for amendment as follows:

10A NCAC 13P .0506 PRACTICE SETTINGS FOR EMS PERSONNEL

(a) Credentialed EMS Personnel may function in the following practice settings in accordance with the protocols approved by the OEMS and by the Medical Director of the EMS System or Specialty Care Transport Program with which they are affiliated:

- (1) at the location of a physiological or psychological illness or ~~injury, including transportation to a treatment facility if required;~~ injury;
- (2) at public or community health facilities in conjunction with public and community health initiatives;
- (3) in hospitals and clinics;
- (4) in residences, facilities, or other locations as part of wellness or injury prevention initiatives within the community and the public health system; ~~and~~
- (5) at mass gatherings or special ~~events;~~ events; and
- (6) community paramedicine programs.

(b) Individuals functioning in an alternative practice setting as defined in Rule ~~.0102(4)~~ .0102 of this Subchapter consistent with the areas identified in Subparagraphs ~~(a)(2)~~ (a)(1) through ~~(a)(4)~~ (a)(5) of this Rule that are not affiliated with an EMS System shall:

- (1) be under the medical oversight of a physician licensed by the North Carolina Medical Board that is associated with the practice setting where the individual will function; and
- (2) be restricted to performing within the scope of practice as defined by the North Carolina Medical Board pursuant to G.S. 143-514 for the individual's level of EMS credential.

(c) Individuals holding a valid EMR or EMT credential that are not affiliated with an approved first responder program or EMS agency and that do not administer medications or utilize advanced airway devices are approved to function as a member of an industrial or corporate first aid safety team without medical oversight or EMS System affiliation.

History Note: Authority G.S. 143-508(d)(7);
 Temporary Adoption Eff. January 1, 2002;
 Eff. April 1, 2003;
 Amended Eff. January 1, 2004;
 Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
 Amended Eff. July 1, 2018; January 1, 2017.

10A NCAC 13P .0904 is proposed for amendment as follows:

10A NCAC 13P .0904 INITIAL DESIGNATION PROCESS

(a) For initial Trauma Center designation, the hospital shall request a consult visit by OEMS and the consult shall occur within one year prior to submission of the RFP.

(b) A hospital interested in pursuing Trauma Center designation shall submit a letter of intent 180 days prior to the submission of an RFP to the OEMS. The letter shall define the hospital's primary trauma catchment area. Simultaneously, Level I or II applicants shall also demonstrate the need for the Trauma Center designation by submitting one original and three copies of documents that include:

- (1) the population to be served and the extent that the population is underserved for trauma care with the methodology used to reach this conclusion;
- (2) geographic considerations, to include trauma primary and secondary catchment area and distance from other Trauma Centers; and
- (3) evidence the Trauma Center will admit at least 1200 trauma patients ~~yearly~~ annually or show that its trauma service will be taking care of at least 240 trauma patients with an ISS greater than or equal to 15 yearly. These criteria shall be met without compromising the quality of care or cost effectiveness of any other designated Level I or II Trauma Center sharing all or part of its catchment area or by jeopardizing the existing Trauma Center's ability to meet this same 240-patient minimum.

(c) The hospital shall be participating in the State Trauma Registry as defined in Rule ~~.0102(61)~~ .0102 of this Subchapter, and submit data to the OEMS weekly a minimum of 12 months prior to application that includes all the Trauma Center's trauma patients as defined in Rule ~~.0102(59)~~ .0102 of this Subchapter who are:

- (1) diverted to an affiliated hospital;
- (2) admitted to the Trauma Center for greater than 24 hours from an ED or hospital;
- (3) die in the ED;
- (4) are DOA; or
- (5) are transferred from the ED to the OR, ICU, or another hospital (including transfer to any affiliated hospital).

(d) OEMS shall review the regional Trauma Registry data from both the applicant and the existing trauma center(s), and ascertain the applicant's ability to satisfy the justification of need information required in ~~Subparagraphs (b)(1) through (3)~~ Paragraph (b) of this Rule. The OEMS shall notify the applicant's primary RAC of the application and provide the regional data submitted by the applicant in ~~Subparagraphs (b)(1) through (3)~~ Paragraph (b) of this Rule for review and comment. The RAC shall be given 30 days to submit written comments to the OEMS.

(e) OEMS shall notify the respective Board of County Commissioners in the applicant's primary catchment area of the request for initial designation to allow for comment during the same 30 day comment period.

(f) OEMS shall notify the hospital in writing of its decision to allow submission of an RFP. If approved, the RAC and Board of County Commissioners in the applicant's primary catchment area shall also be notified by the OEMS that an RFP will be submitted.

(g) Once the hospital is notified that an RFP will be accepted, the hospital shall complete and submit an electronic copy of the completed RFP with signatures to the OEMS at least 45 days prior to the proposed site visit date.

(h) The RFP shall demonstrate that the hospital meets the standards for the designation level applied for as found in Rule .0901 of this Section.

(i) If OEMS does not recommend a site visit based upon failure to comply with Rule .0901 of this Section, the OEMS shall send the written reasons to the hospital within 30 days of the decision. The hospital may reapply for designation within six months following the submission of an updated RFP. If the hospital fails to respond within six months, the hospital shall reapply following the process outlined in Paragraphs (a) through (h) of this Rule.

(j) If after review of the RFP, the OEMS recommends the hospital for a site visit, the OEMS shall notify the hospital within 30 days and the site visit shall be conducted within six months of the recommendation. The hospital and the OEMS shall agree on the date of the site visit.

(k) Except for OEMS representatives, any in-state reviewer for a Level I or II visit shall be from outside the local or adjacent RAC, unless mutually agreed upon by the OEMS and the trauma center seeking designation where the hospital is located. The composition of a Level I or II state site survey team shall be as follows:

- (1) one out-of-state trauma surgeon who is a Fellow of the ACS, experienced as a site surveyor, who shall be the primary reviewer;
- (2) one in-state emergency physician who currently works in a designated trauma center, is a member of the American College of Emergency Physicians or American Academy of Emergency Medicine, and is boarded in emergency medicine by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
- (3) one in-state trauma surgeon who is a member of the North Carolina Committee on Trauma;
- (4) for Level I designation, one out-of-state trauma program manager with an equivalent license from another state;
- (5) for Level II designation, one in-state program manager who is licensed to practice ~~professional~~ nursing in North Carolina in accordance with the Nursing Practice Act, Article 9A, Chapter 90 of the North Carolina General Statutes; and
- (6) OEMS Staff.

(l) All site team members for a Level III visit shall be from in-state, and, except for the OEMS representatives, shall be from outside the local or adjacent RAC where the hospital is located. The composition of a Level III state site survey team shall be as follows:

- (1) one trauma surgeon who is a Fellow of the ACS, who is a member of the North Carolina Committee on Trauma and shall be the primary reviewer;
- (2) one emergency physician who currently works in a designated trauma center, is a member of the North Carolina College of Emergency Physicians or American Academy of Emergency Medicine, and is boarded in emergency medicine by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;
- (3) one trauma program manager who is licensed to practice ~~professional~~ nursing in North Carolina in accordance with the Nursing Practice Act, Article 9A, Chapter 90 of the North Carolina General Statutes; and
- (4) OEMS Staff.

(m) On the day of the site visit, the hospital shall make available all requested patient medical charts.

(n) The primary reviewer of the site review team shall give a verbal post-conference report representing a consensus of the site review team. The primary reviewer shall complete and submit to the OEMS a written consensus report within 30 days of the site visit.

(o) The report of the site survey team and the staff recommendations shall be reviewed by the State Emergency Medical Services Advisory Council at its next regularly scheduled meeting following the site visit. Based upon the site visit report and the staff recommendation, the State Emergency Medical Services Advisory Council shall recommend to the OEMS that the request for Trauma Center designation be approved or denied.

(p) All criteria defined in Rule .0901 of this Section shall be met for initial designation at the level requested.

(q) Hospitals with a deficiency(ies) resulting from the site visit shall be given up to 12 months to demonstrate compliance. Satisfaction of deficiency(ies) may require an additional site visit. The need for an additional site visit is shall be determined on a case-by-case basis based on the type of deficiency. If compliance is not demonstrated within the time period set by OEMS, the hospital shall submit a new application and updated RFP and follow the process outlined in Paragraphs (a) through (h) of this Rule.

(r) The final decision regarding Trauma Center designation shall be rendered by the OEMS.

- (s) The OEMS shall notify the hospital in writing of the State Emergency Medical Services Advisory Council's and OEMS' final recommendation within 30 days of the Advisory Council meeting.
- (t) If a trauma center changes its trauma program administrative structure such that the trauma service, trauma Medical Director, trauma program manager, or trauma registrar are relocated on the hospital's organizational chart at any time, it shall notify OEMS of this change in writing within 30 days of the occurrence.
- (u) Initial designation as a trauma center shall be valid for a period of three years.

*History Note: Authority G.S. 131E-162; 143-508(d)(2);
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, ~~2017~~ 2017;
Amended Eff. July 1, 2018.*

10A NCAC 13P .1502 is proposed for amendment as follows:

10A NCAC 13P .1502 LICENSED EMS PROVIDERS

(a) The OEMS shall deny an initial or renewal EMS Provider license for any of the following reasons:

- (1) significant failure to comply, as defined in Rule ~~.0102(45)~~ .0102 of this Subchapter, with the applicable licensing requirements in Rule .0204 of this Subchapter;
- (2) making false statements or representations to the OEMS or willfully concealing information in connection with an application for licensing;
- (3) tampering with or falsifying any record used in the process of obtaining an initial license or in the renewal of a license; or
- (4) disclosing information as defined in Rule .0223 of this Subchapter that is determined by OEMS ~~staff~~ staff, based upon review of documentation, to disqualify the applicant from licensing.

(b) The Department shall amend any EMS Provider license by amending it to reduce the license from a full license to a provisional license whenever the Department finds that:

- (1) the licensee failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under that Article;
- (2) there is a probability that the licensee can take corrective measures to resolve the issue of non-compliance with Rule .0204 of this Subchapter, and be able ~~thereafter~~ to remain in compliance within a reasonable length of time determined by OEMS staff on a case-by-case basis; and
- (3) there is a probability, determined by OEMS staff using their professional judgment, based upon analysis of the licensee's ability to take corrective measures to resolve the issue of non-compliance with the licensure rules, that the licensee will be able thereafter to remain in compliance with the licensure rules.

(c) The Department shall give the licensee written notice of the amendment of the EMS Provider license. This notice shall be given personally or by certified mail and shall set forth:

- (1) the duration of the provisional EMS Provider license;
- (2) the factual allegations;
- (3) the statutes or rules alleged to be violated; and
- (4) notice of the EMS provider's right to a contested case hearing, as set forth in Rule .1509 of this Subchapter, on the amendment of the EMS Provider license.

(d) The provisional EMS Provider license is effective upon its receipt by the licensee and shall be posted in a location at the primary business location of the EMS Provider, accessible to public view, in lieu of the full license. Pursuant to G.S. 131E-155.1(d), the provisional license remains in effect until the Department:

- (1) restores the licensee to full licensure status; or
- (2) revokes the licensee's license.

(e) The Department shall revoke or suspend an EMS Provider license whenever the Department finds that the licensee:

- (1) failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under that Article and it is not probable that the licensee can remedy the licensure deficiencies within 12 months or less;

- (2) failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under that Article and, although the licensee may be able to remedy the deficiencies, it is not probable that the licensee will be able to remain in compliance with licensure rules;
- (3) failed to comply with the provision of G.S. 131E, Article 7, and the rules adopted under that Article that endanger the health, safety, or welfare of the patients cared for or transported by the licensee;
- (4) obtained or attempted to obtain an ambulance permit, EMS nontransporting vehicle permit, or EMS Provider license through fraud or misrepresentation;
- (5) continues to repeat the same deficiencies placed on the licensee in previous compliance site visits;
- (6) has recurring failure to provide emergency medical care within the defined EMS service area in a manner as determined by the EMS System;
- (7) failed to disclose or report information in accordance with Rule .0223 of this Subchapter;
- (8) was deemed by OEMS to place the public at risk because the ~~owner~~ owner, or any ~~officer~~ officer, or agent was convicted in any court of a crime involving fiduciary misconduct or a conviction of a felony;
- (9) altered, destroyed, attempted to destroy, withheld, or delayed release of evidence, records, or documents needed for a complaint investigation being conducted by the OEMS; or
- (10) continues to operate within an EMS System after a Board of County Commissioners ~~has~~ terminated its affiliation with the licensee, resulting in a violation of the licensing requirement set forth in Rule ~~.0204(a)(1)~~ .0204 of this Subchapter.

(f) The Department shall give the EMS Provider written notice of revocation. This notice shall be given personally or by certified mail and shall set forth:

- (1) the factual allegations;
- (2) the statutes or rules alleged to be violated; and
- (3) notice of the EMS Provider's right to a contested case hearing, as set forth in Rule .1509 of this Section, on the revocation of the EMS Provider's license.

(g) The issuance of a provisional EMS Provider license is not a procedural prerequisite to the revocation or suspension of a license pursuant to Paragraph (e) of this Rule.

History Note: Authority G.S. 131E-155.1(d); 143-508(d)(10);
 Eff. January 1, 2013;
 Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
 Amended Eff. July 1, 2018; January 1, 2017.

10A NCAC 13P .1505 is proposed for amendment as follows:

10A NCAC 13P .1505 EMS EDUCATIONAL INSTITUTIONS

(a) For the purpose of this Rule, "focused review" means an evaluation by the OEMS of an educational institution's corrective actions to remove contingencies that are a result of deficiencies identified in the initial or renewal application process.

(b) The Department shall deny the initial or renewal designation, without first allowing a focused review, of an EMS Educational Institution for any of the following reasons:

- (1) significant failure to comply with the provisions of Section .0600 of this Subchapter; or
- (2) attempting to obtain an EMS Educational Institution designation through fraud or misrepresentation.

(c) When an EMS Educational Institution is required to have a focused review, it shall demonstrate compliance with the provisions of Section .0600 of this Subchapter within 12 months or less.

(d) The Department shall revoke an EMS Educational Institution designation at any time whenever the Department finds that the EMS Educational Institution has significant failure to comply, as defined in Rule ~~.0102(45)~~ .0102 of this Subchapter, with the provisions of Section .0600 of this Subchapter, and:

- (1) it is not probable that the EMS Educational Institution can remedy the deficiencies within 12 months or less as determined by OEMS staff based upon analysis of the educational institution's ability to take corrective measures to resolve the issue of non-compliance with Section .0600 of this Subchapter;
- (2) although the EMS Educational Institution may be able to remedy the deficiencies, it is not probable that the EMS Educational Institution shall be able to remain in compliance with credentialing rules;
- (3) failure to produce records upon request as required in Rule .0601(b)(6) of this Subchapter;
- (4) the EMS Educational Institution failed to meet the requirements of a focused review within 12 months, as set forth in Paragraph (c) of this Rule;
- (5) the failure to comply endangered the health, safety, or welfare of patients cared for as part of an EMS educational program as determined by OEMS staff in their professional judgment based upon a complaint investigation, in consultation with the Department and Department of Justice, to verify the results of the investigations are sufficient to initiate enforcement action pursuant to G.S. 150B; or
- (6) the EMS Educational Institution altered, destroyed, or attempted to destroy evidence needed for a complaint investigation.

(e) The Department shall give the EMS Educational Institution written notice of revocation and denial. This notice shall be given personally or by certified mail and shall set forth:

- (1) the factual allegations;
- (2) the statutes or rules alleged to be violated; and
- (3) notice of the EMS Educational Institution's right to a contested case hearing, set forth in Rule .1509 of this Section, on the revocation of the designation.

(f) Focused review is not a procedural prerequisite to the revocation of a designation as set forth in Rule .1509 of this Section.

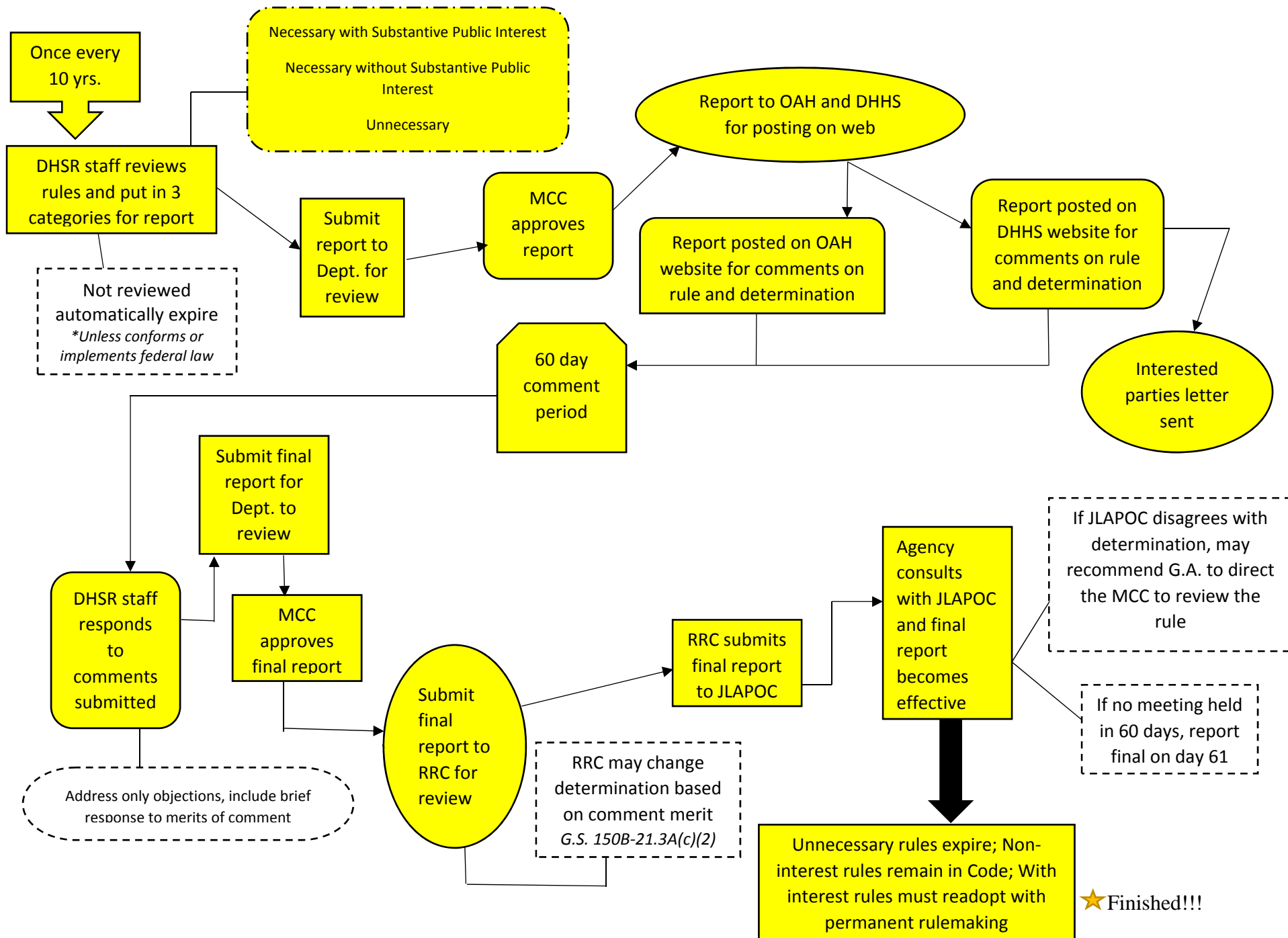
(g) If determined by the educational institution that suspending its approval to offer EMS educational programs is necessary, the EMS Educational Institution may voluntarily surrender its credential without explanation by submitting a written request to the OEMS stating its intention. The voluntary surrender shall not affect the original expiration date of the EMS Educational Institution's designation. To reactivate the designation:

- (1) the institution shall provide OEMS written documentation requesting reactivation; and

- (2) the OEMS shall verify the educational institution is compliant with all credentialing requirements set forth in Section .0600 of this Subchapter prior to reactivation of the designation by the OEMS.
- (h) If the institution fails to resolve the issues that resulted in a voluntary surrender, the Department shall revoke the EMS Educational Institution designation.
- (i) In the event of a revocation or voluntary surrender, the Department shall provide written notification to all EMS Systems within the EMS Educational Institution's defined service area. The Department shall provide written notification to all EMS Systems within the EMS Educational Institution's defined service area when the voluntary surrender reactivates to full credential.
- (j) When an accredited EMS Educational Institution as defined in Rule .0605 of this Subchapter has administrative action taken against its accreditation, the OEMS shall determine if the cause of action is sufficient for revocation of the EMS Educational Institution designation or imposing a focused review pursuant to Paragraphs (b) and (c) of this Rule is warranted.

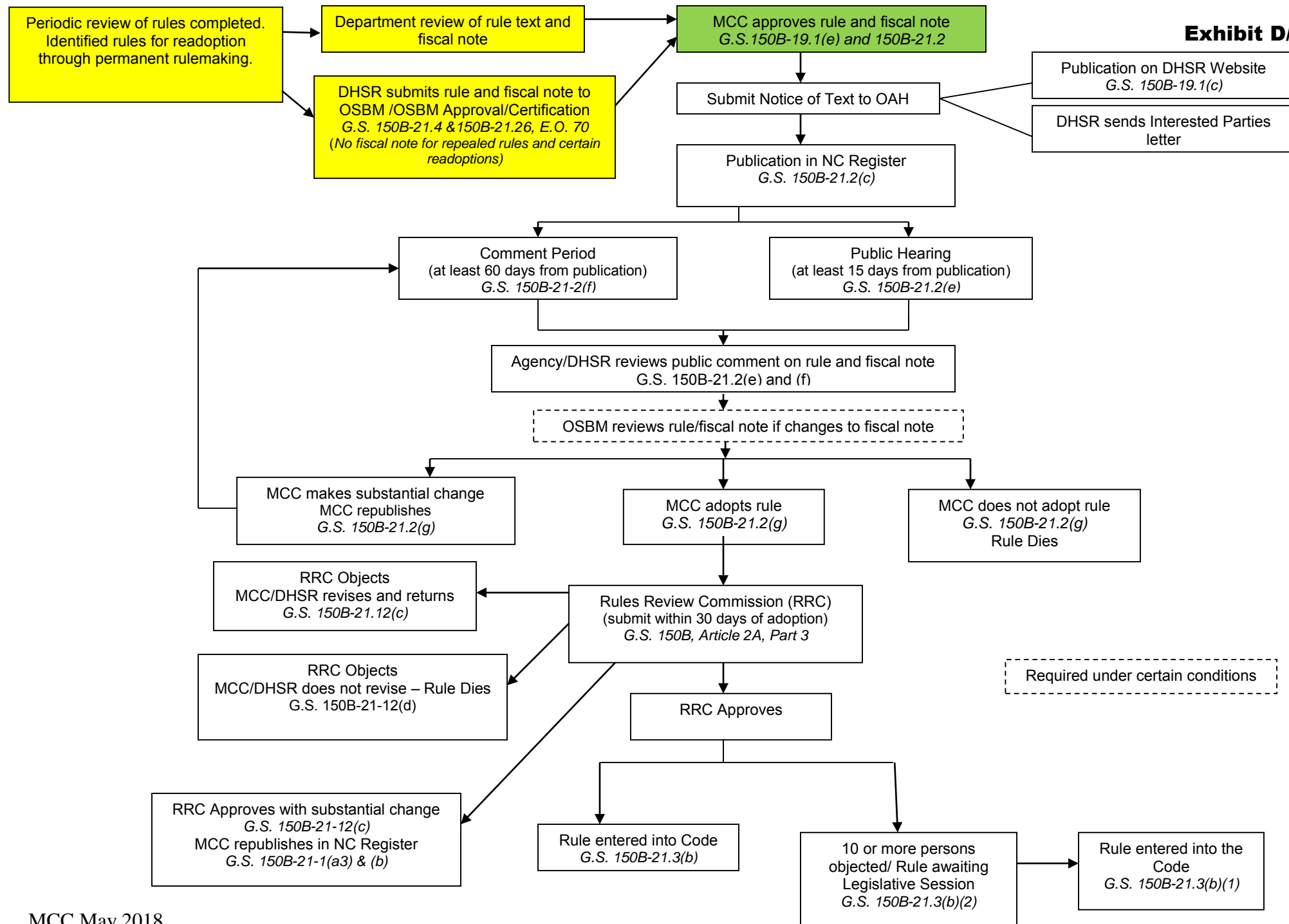
History Note: Authority G.S. 143-508(d)(4); 143-508(d)(10);
Eff. January 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2,
2016;
Amended Eff. July 1, 2018; January 1, 2017.

Periodic Rules Review Process for: Rulemaking Rules - 10A NCAC 14A, Section .0300 – Hearings, Transfers & Discharges



Readoptions through Permanent Rulemaking Process for: Nursing Home Hearings, Transfers & Discharges Rules; 14A .0301-.0303

Exhibit D/1



MCC Action: Initiate Rulemaking

1 10A NCAC 14A .0301 is proposed for readoption with substantive changes as follows:

2

3 **10A NCAC 14A .0301 DEFINITIONS**

4 The following definitions ~~will~~ apply throughout this Subchapter:

5 (1) ~~"Agency" means the Hearing Officer and his office in the Division of Health Service Regulation,~~
6 ~~Department of Health and Human Services.~~

7 (2) ~~"Dismissal" means the dismissal of a request for a hearing if:~~

8 (a) ~~the applicant withdraws the request in writing; or~~

9 (b) ~~the applicant fails to appear at a scheduled hearing without good cause.~~

10 (3) ~~"Division" means the North Carolina Division of Health Service Regulation of the Department of~~
11 ~~Health and Human Services.~~

12 (4)(1) "Facility" means a nursing facility which meets the requirements of the Social Security Act as is
13 defined in 42 CFR ~~483.5,~~ 483.5 which is herein incorporated by reference, including subsequent
14 amendments and editions. The Code of Federal Regulations may be accessed free of charge at
15 http://www.access.gpo.gov/nara/cfr/waisidx_08/42cfr483_08.

16 (5)(2) "Hearing Officer" means the person at the Hearing Unit designated to preside over hearings between
17 residents and nursing facility providers regarding transfers and discharges.

18 (3) "Hearing Unit" means the Chief Hearing Officer and his or her staff in the Division of Medical
19 Assistance of the Department of Health and Human Services.

20 (6)(4) "Notice" means a written notification of transfer or ~~discharge~~ discharge, as required by 42 CFR
21 483.15 (c), by the facility to the resident and ~~either an immediate family member, if known, or if an~~
22 ~~immediate family member is not known, the authorized representative.~~ The resident shall be handed
23 the notice on the same day that it is dated. The notice must include: the resident's representative as
24 defined in 42 CFR 483.5.

25 (a) ~~the reason for the transfer or discharge;~~

26 (b) ~~the effective date of the transfer or discharge;~~

27 (c) ~~the location to which the resident is transferred or discharged;~~

28 (d) ~~a statement that the resident has the right to appeal to the Hearing Officer;~~

29 (e) ~~the name, address, and telephone number of the state Long Term Care Ombudsman;~~

30 (f) ~~for nursing facility residents with developmental disabilities, the mailing address and~~
31 ~~telephone number of the agency responsible for the protection and advocacy of~~
32 ~~developmentally disabled individuals established under Part C of the Developmental~~
33 ~~Disabilities Assistance and Bill of Rights Act;~~

34 (g) ~~for nursing facility residents who are mentally ill, the mailing address and telephone~~
35 ~~number of the agency responsible for the protection and advocacy of mentally ill~~
36 ~~individuals established under the Protection and Advocacy for Mentally Ill Individuals Act;~~

1 (h) ~~_____ a statement that the resident has the right to review his records not later than five days prior~~
2 ~~to a hearing; and~~

3 (i) ~~_____ a statement that the appeal will be at no cost to the resident.~~

4 ~~(7)(5)~~ "Request for a Hearing" means a ~~clear expression, in writing,~~ written expression by the
5 resident ~~or or, either an immediate family member, if known, or if an immediate family member is~~
6 ~~not known, the authorized or, legal representative, that he or she wants the opportunity to present~~
7 ~~his or her case to the hearing officer. Hearing Officer. The "Request for Hearing Form" will suffice~~
8 ~~as a clear, expression, in writing, that a hearing is desired.~~

9 ~~(8)~~ "Request for Hearing Form" means a form which that is to be given to the resident and either an
10 ~~immediate family member, if known, or if an immediate family member is not known, the~~
11 ~~authorized representative, simultaneously with the Notice of Transfer or Discharge. The request for~~
12 ~~hearing form must include at the least:~~

13 ~~(a) _____ the date of Notice of Transfer or Discharge;~~

14 ~~(b) _____ the date to be transferred or discharged;~~

15 ~~(c) _____ the Division of Health Service Regulation's correct mailing address and phone number;~~

16 ~~(d) _____ the resident's name, address, telephone number, and social security number;~~

17 ~~(e) _____ the nursing facility's name and address;~~

18 ~~(f) _____ the name, address, and telephone number of authorized representative; and~~

19 ~~(g) _____ space to elect the option of a hearing by telephone or in person.~~

20 ~~(9)(6)~~ "Resident" means any person who is receiving treatment or long-term care in a facility.

21 ~~(10)(7)~~ "Serve" or "Service" means personal delivery, delivery by first class or certified United States Postal
22 Service ~~mail mail,~~ or delivery by licensed overnight express mail, postage prepaid and addressed to
23 the party at his or her last known address. ~~Service by mail or licensed overnight express mail is~~
24 ~~complete upon placing the item to be served, enclosed in a wrapper addressed to the person to be~~
25 ~~served, in an official depository of the United States Postal Service or upon delivery, postage prepaid~~
26 ~~and wrapped in a wrapper addressed to the person to be served, to an agent of the overnight express~~
27 ~~mail service. For purposes of service on the Division, the Hearing Officer of the Division shall be~~
28 ~~the designated agent.~~

29
30 *History Note:* Authority G.S. 143B-165(10); 42 U.S.C.S. 1396r(e)(3) and (f)(3); U.S.C. 1395i-3(c)(2)(B)(iii); 42
31 U.S.C. 1396r(e)(3); 42 U.S.C. 1396r(f)(3); 42 C.F.R. 483.5; 42 C.F.R. 483.12; 42 CFR
32 483.15(c); G.S. 143B-165(10);
33 Eff. August 3, 1992-1992;
34 Readopted Eff. January 1, 2019.

MCC Action: Initiate Rulemaking

1 10A NCAC 14A .0302 is proposed for readoption with substantive changes as follows:

2

3 **10A NCAC 14A .0302 GENERAL**

4 ~~(a) The Division has established an appeal process for nursing facility residents who have been notified of transfer or~~
5 ~~discharge. All residents who have~~ Any resident who has been advised of the date of a transfer or discharge
6 in ~~writing,~~ writing may request that the ~~Division~~ Hearing Officer set a date for a ~~fair~~ hearing in accordance with ~~and~~
7 ~~subject to~~ these Rules. Hearing procedures are held in accordance with rules in 10A NCAC 22H, Section .0200, which
8 is herein incorporated by reference, including subsequent amendments and editions. These rules may be accessed free
9 of charge at <http://reports.oah.state.nc.us/ncac.asp>.

10 ~~(b) The Rules of Civil Procedure as contained in G.S. 1A-1 and the General Rules of Practice for the Superior and~~
11 ~~District Courts as authorized by G.S. 7A-34 and found in the Rules Volume of the North Carolina General Statutes~~
12 ~~shall not apply in any hearings held by the Division Hearing Officer unless another specific statute or rule provides~~
13 ~~otherwise. Division hearings are not hearings within the meaning of G.S. Chapter 150B and will not be governed by~~
14 ~~the provision of that Chapter unless otherwise stated in these Rules. Parties may be represented by counsel at the~~
15 ~~hearing.~~

16

17 *History Note: Authority G.S. 143B-165(10); 42 U.S.C.S. 1396r(e)(3) and (f)(3); U.S.C. 1395i-3(c)(2)(B)(iii); 42*
18 *U.S.C. 1396r(e)(3); 42 U.S.C. 1396r(f)(3); 42 C.F.R. 483.12; CFR 483.15(c); G.S. 143B-165(10);*
19 *Eff. August 3, 1992-1992;*
20 *Readopted Eff. January 1, 2019.*

MCC Action: Initiate Rulemaking

1 10A NCAC 14A .0303 is proposed for readoption with substantive changes as follows:

2

3 **10A NCAC 14A .0303 INITIATING A HEARING**

4 ~~(a) In order to initiate a hearing with the Hearing Officer, hearing, a resident must first have been served by the facility~~
5 ~~administrator with a written Notice of Transfer or Discharge notice and must shall file a Request for Hearing in~~
6 ~~accordance with the Rules in 10 NCAC 14A .0300. rules in 10A NCAC 22H, Section .0200. The Request for Hearing~~
7 ~~must be in writing and must be signed by the resident. A Request for Hearing form shall be provided to the resident~~
8 ~~by the facility for this purpose.~~

9 ~~(b) The hearing is a mechanism for listening to appeals by residents concerning disputes over transfers and discharges.~~
10 ~~The hearing shall be narrowly focused on discharge and transfer issues between the nursing facility and the resident~~
11 ~~and shall not involve Medicaid matters such as eligibility, which is the responsibility of the Medicaid hearing officer.~~

12 ~~(c) Should an appeal of the Notice of Transfer or Discharge be desired, a Request for a Hearing, accompanied by the~~
13 ~~Notice of Transfer or Discharge, shall be served to the Hearing Officer and must be received by him no later than 11~~
14 ~~days from the date of the facility's Notice of Transfer or Discharge. If the request for hearing has not been received~~
15 ~~within 11 days, the resident shall waive his right to appeal. The resident must be notified of the option for the hearing~~
16 ~~to be in person (face to face) or by telephone.~~

17 ~~(d) The facility administrator must make available to the resident information and records at least five working days~~
18 ~~prior to the hearing to enable an opportunity for review and preparation. The facility administrator must forward~~
19 ~~identical information relevant to the transfer or discharge to the agency, to be received at least five working days prior~~
20 ~~to the hearing. A resident must authorize release of his medical records to the hearing officer.~~

21

22 *History Note: Authority G.S. 143B-165(10); 42 U.S.C.S. 1396r(e)(3) and (f)(3); U.S.C. 1395i-3(c)(2)(B)(iii); 42*
23 *U.S.C. 1396r(e)(3); 42 U.S.C. 1396r(f)(3); 42 C.F.R. 483.12; CFR 483.15(c); G.S. 143B-165(10);*
24 *Eff. August 3, 1992; 1992;*
25 *Readopted Eff. January 1, 2019.*

**Fiscal Impact Analysis of Permanent Rule Readoption
10A NCAC 14A, Section .0300, Hearings, Transfers and Discharges**

Agency Proposing Rule Change

North Carolina Medical Care Commission

Contact Persons

Nadine Pfeiffer, Rule Review Manager, (919) 855-3811

Beverly Speroff, Assistant Chief, (919) 855-4555

Becky Wertz, Section Chief, (919) 855-4850

Impact Summary

Federal government impact:	No Impact
State government impact:	No Impact
Local government impact:	No Impact
Substantial impact:	No Impact

Title of Rules

10A NCAC 14A .0301 Definitions (readopt with substantive changes).

10A NCAC 14A .0302 General (readopt with substantive changes).

10A NCAC 14A .0303 Initiating a Hearing (readopt with substantive changes).

(See proposed rules in Appendix.)

Statutory Authority

42 U.S.C. 1395i-3(c)(2)(B)(iii)

42 U.S.C. 1396r (e)(3)

42 U.S.C. 1396r (f) (3)

42 C.F.R. 483.15(c)

G.S. 143B-165(10)

Introductory Note

There are 427 nursing homes that participate in Medicare and Medicaid in North Carolina. Before these homes issue a discharge notice to a resident residing in the certified portion of the home, a discharge notice must be issued to the resident that includes the right to appeal the discharge. This information must include the contact information for the entity that receives the appeal requests and how to receive the form. In North Carolina, the DHHS Hearing Office (which is under the Division of Medical Assistance) is the entity that receives nursing home appeals. The Medical Care Commission (MCC) determined it was necessary to readopt 10A NCAC 14A .0301 - .0303 and to refer to the existing DHHS hearing office process.

Background

The rules in 10A NCAC 14A have not been amended since their initial effective date of August 3, 1992. The Division of Medical Assistance (DMA) adopted rules entitled, 10A NCAC 22H .0200 – Hearings: Transfer and Discharges effective April 1, 1994. These are the rules that have been implemented over the past 23 years.

Under authority of N.C.G.S. 150B-21-3A, Periodic review and expiration of existing rules, the MCC, Rules Review Commission and the Joint Legislative Administrative Procedure Oversight Committee approved the final Subchapter report with classifications for the rules located at 10A NCAC 14A – Rulemaking – on May 23, 2017, November 16, 2017, and January 9, 2018, respectively. The following rules were classified as “Necessary with Substantive Public Interest” in this report: 10A NCAC 14A .0301, .0302, and .0303. Therefore, in accordance with G.S. 150B-21.3A(c)(2)(g), these rules, must be readopted as though the rules were new rules.

The MCC determined readoption of rules 10A NCAC 14A .0301 - .0303 was needed to carry out the flow of authority from the Federal nursing home requirements, to the Division of Health Service Regulation Director rules and then to the DMA DHHS Hearing Unit process.

Rule Summary and Anticipated Fiscal Impact

10A NCAC 14A .0301 Definitions

The agency is proposing to readopt the rule with substantive changes. Definitions that no longer appeared in any subsequent rules were deleted. We clarified that the Hearing Officer was located at the Hearing Unit. We added a definition for the Hearing Unit. We referenced the federal definition for Notice and deleted the definition in the rule. We updated authorities in the history note.

Fiscal Impact

There is no Federal, State or local fiscal impact associated with the readoption of this rule. The readoption simply cleans up the code and continues the same process for hearings that has been in existence since 1994.

10A NCAC 14A .0302 General

The agency is proposing to readopt the rule with substantive changes. We have clarified that it is not the Division of Health Service Regulation that is establishing the appeal process and that it is not the Division of Health Service Regulation’s Hearing Officer and finally that it is not the Division of Health Service Regulation’s hearings. We deleted paragraph (b) because it was confusing.

Fiscal Impact

There is no Federal, State or local fiscal impact associated with the readoption of this rule. The readoption simply cleans up the code and continues the same process for hearings that has been in existence since 1994.

10A NCAC 14A .0303 Initiating A Hearing

The agency is proposing to readopt the rule with substantive changes. We have clarified that a request for hearing must be filed in accordance with 10A NCAC 22H, Section .0200. We have deleted all process steps for initiating a hearing in this rule.

Fiscal Impact

There is no Federal, State or local fiscal impact associated with the readoption of this rule. The readoption simply cleans up the code and continues the same process for hearings that has been in existence since 1994.

10A NCAC 14A .0301 is proposed for readoption with substantive changes as follows:

10A NCAC 14A .0301 DEFINITIONS

The following definitions ~~will~~ apply throughout this Subchapter:

- (1) ~~"Agency" means the Hearing Officer and his office in the Division of Health Service Regulation, Department of Health and Human Services.~~
- (2) ~~"Dismissal" means the dismissal of a request for a hearing if:~~
- (a) ~~the applicant withdraws the request in writing; or~~
- (b) ~~the applicant fails to appear at a scheduled hearing without good cause.~~
- (3) ~~"Division" means the North Carolina Division of Health Service Regulation of the Department of Health and Human Services.~~
- (4)(1) "Facility" means a nursing facility which meets the requirements of the Social Security Act as is defined in 42 CFR 483.5. 483.5 which is herein incorporated by reference, including subsequent amendments and editions. The Code of Federal Regulations may be accessed free of charge at http://www.access.gpo.gov/nara/cfr/waisidx_08/42cfr483_08.
- (5)(2) "Hearing Officer" means the person at the Hearing Unit designated to preside over hearings between residents and nursing facility providers regarding transfers and discharges.
- (3) ~~"Hearing Unit" means the Chief Hearing Officer and his or her staff in the Division of Medical Assistance of the Department of Health and Human Services.~~
- (6)(4) "Notice" means a written notification of transfer or ~~discharge~~ discharge, as required by 42 CFR 483.15 (c), by the facility to the resident and ~~either an immediate family member, if known, or if an immediate family member is not known, the authorized representative. The resident shall be handed the notice on the same day that it is dated. The notice must include: the resident's representative as defined in 42 CFR 483.5.~~
- (a) ~~the reason for the transfer or discharge;~~
- (b) ~~the effective date of the transfer or discharge;~~
- (c) ~~the location to which the resident is transferred or discharged;~~
- (d) ~~a statement that the resident has the right to appeal to the Hearing Officer;~~
- (e) ~~the name, address, and telephone number of the state Long Term Care Ombudsman;~~
- (f) ~~for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act;~~
- (g) ~~for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill~~

~~individuals established under the Protection and Advocacy for Mentally Ill Individuals Act;~~

~~(h) — a statement that the resident has the right to review his records not later than five days prior to a hearing; and~~

~~(i) — a statement that the appeal will be at no cost to the resident.~~

~~(7)(5) "Request for a Hearing" means a clear expression, in writing, written expression by the resident or or, either an immediate family member, if known, or if an immediate family member is not known, the authorized or, legal representative, that he or she wants the opportunity to present his or her case to the hearing officer. Hearing Officer. The "Request for Hearing Form" will suffice as a clear, expression, in writing, that a hearing is desired.~~

~~(8) — "Request for Hearing Form" means a form which that is to be given to the resident and either an immediate family member, if known, or if an immediate family member is not known, the authorized representative, simultaneously with the Notice of Transfer or Discharge. The request for hearing form must include at the least:~~

~~(a) — the date of Notice of Transfer or Discharge;~~

~~(b) — the date to be transferred or discharged;~~

~~(c) — the Division of Health Service Regulation's correct mailing address and phone number;~~

~~(d) — the resident's name, address, telephone number, and social security number;~~

~~(e) — the nursing facility's name and address;~~

~~(f) — the name, address, and telephone number of authorized representative; and~~

~~(g) — space to elect the option of a hearing by telephone or in person.~~

~~(9)(6) "Resident" means any person who is receiving treatment or long-term care in a facility.~~

~~(10)(7) "Serve" or "Service" means personal delivery, delivery by first class or certified United States Postal Service mail mail, or delivery by licensed overnight express mail, postage prepaid and addressed to the party at his or her last known address. —Service by mail or licensed overnight express mail is complete upon placing the item to be served, enclosed in a wrapper addressed to the person to be served, in an official depository of the United States Postal Service or upon delivery, postage prepaid and wrapped in a wrapper addressed to the person to be served, to an agent of the overnight express mail service. For purposes of service on the Division, the Hearing Officer of the Division shall be the designated agent.~~

*History Note: Authority G.S. 143B-165(10); 42 U.S.C.S. 1396r(e)(3) and (f)(3); U.S.C. 1395i-3(c)(2)(B)(iii); 42 U.S.C. 1396r(e)(3); 42 U.S.C. 1396r(f)(3); 42 C.F.R. 483.5; 42 C.F.R. 483.12; 42 CFR 483.15(c); G.S. 143B-165(10);
Eff. August 3, 1992-1992;
Readopted Eff. January 1, 2019.*

10A NCAC 14A .0302 is proposed for readoption with substantive changes as follows:

10A NCAC 14A .0302 GENERAL

~~(a) The Division has established an appeal process for nursing facility residents who have been notified of transfer or discharge. All residents who have~~ Any resident who has been advised of the date of a transfer or discharge in ~~writing.~~ writing may request that the ~~Division~~ Hearing Officer set a date for a ~~fair~~ hearing in accordance with ~~and~~ subject to these Rules. Hearing procedures are held in accordance with rules in 10A NCAC 22H, Section .0200, which is herein incorporated by reference, including subsequent amendments and editions. These rules may be accessed free of charge at <http://reports.oah.state.nc.us/ncac.asp>.

~~(b) The Rules of Civil Procedure as contained in G.S. 1A-1 and the General Rules of Practice for the Superior and District Courts as authorized by G.S. 7A-34 and found in the Rules Volume of the North Carolina General Statutes shall not apply in any hearings held by the Division Hearing Officer unless another specific statute or rule provides otherwise. Division hearings are not hearings within the meaning of G.S. Chapter 150B and will not be governed by the provision of that Chapter unless otherwise stated in these Rules. Parties may be represented by counsel at the hearing.~~

*History Note: Authority G.S. 143B-165(10); 42 U.S.C.S. 1396r(e)(3) and (f)(3); U.S.C. 1395i-3(c)(2)(B)(iii); 42 U.S.C. 1396r(e)(3); 42 U.S.C. 1396r(f)(3); 42 C.F.R. 483.12; CFR 483.15(c); G.S. 143B-165(10); Eff. August 3, 1992-1992;
Readopted Eff. January 1, 2019.*

10A NCAC 14A .0303 is proposed for readoption with substantive changes as follows:

10A NCAC 14A .0303 INITIATING A HEARING

~~(a) In order to initiate a hearing with the Hearing Officer, hearing, a resident must first have been served by the facility administrator with a written Notice of Transfer or Discharge notice and must shall file a Request for Hearing in accordance with the Rules in 10 NCAC 14A .0300; rules in 10A NCAC 22H, Section .0200. The Request for Hearing must be in writing and must be signed by the resident. A Request for Hearing form shall be provided to the resident by the facility for this purpose.~~

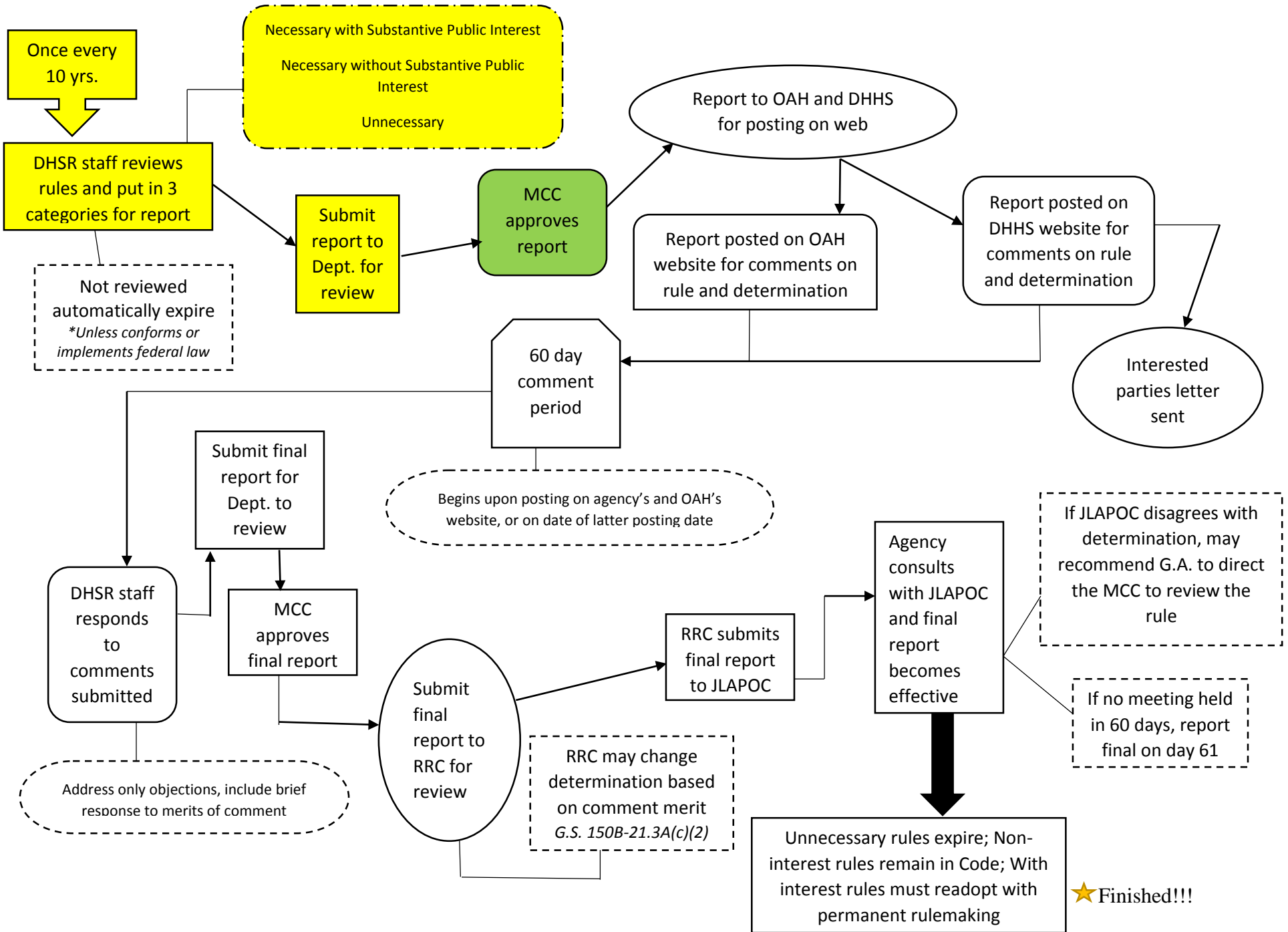
~~(b) The hearing is a mechanism for listening to appeals by residents concerning disputes over transfers and discharges. The hearing shall be narrowly focused on discharge and transfer issues between the nursing facility and the resident and shall not involve Medicaid matters such as eligibility, which is the responsibility of the Medicaid hearing officer.~~

~~(c) Should an appeal of the Notice of Transfer or Discharge be desired, a Request for a Hearing, accompanied by the Notice of Transfer or Discharge, shall be served to the Hearing Officer and must be received by him no later than 11 days from the date of the facility's Notice of Transfer or Discharge. If the request for hearing has not been received within 11 days, the resident shall waive his right to appeal. The resident must be notified of the option for the hearing to be in person (face to face) or by telephone.~~

~~(d) The facility administrator must make available to the resident information and records at least five working days prior to the hearing to enable an opportunity for review and preparation. The facility administrator must forward identical information relevant to the transfer or discharge to the agency, to be received at least five working days prior to the hearing. A resident must authorize release of his medical records to the hearing officer.~~

*History Note: Authority G.S. 143B-165(10); 42 U.S.C.S. 1396r(e)(3) and (f)(3); U.S.C. 1395i-3(c)(2)(B)(iii); 42 U.S.C. 1396r(e)(3); 42 U.S.C. 1396r(f)(3); 42 C.F.R. 483.12; CFR 483.15(c); G.S. 143B-165(10); Eff. August 3, 1992- 1992;
Readopted Eff. January 1, 2019.*

Periodic Rules Review Process for: Licensing of Family Care Homes - 10A NCAC 13G



Key:
 * Rulemaking will result
 Ø Unnecessary

Initial Category Determination Evaluation Report

Exhibit E/1

G.S. 150B-21.3A Report for Subchapter 13G, LICENSING OF FAMILY CARE HOMES

Agency - Medical Care Commission

Comment Period - 5/25/18 - 7/24/18

Subchapter	Rule Section	Rule Citation	Rule Name	Date and Last Agency Action on the Rule	Agency Determination [150B-21.3A(c)(1)(a)]	Implements or Conforms to Federal Regulation [150B-21.3A(e)]	Federal Regulation Citation	Public Comment Received [150B-21.3A(c)(1)]	Agency Determination Following Public Comment [150B-21.3A(c)(1)]	RRC Determination of Public Comments [150B-21.3A(c)(2)]	RRC Final Determination of Status of Rule for Report to APO [150B-21.3A(c)(2)]	OAH Next Steps
	SECTION .0200 - LICENSING	10A NCAC 13G .0201	DEFINITIONS	Eff. July 1, 2000	Necessary without substantive public interest	No		Select One	Select One	Select One	Select One	Select One
*		10A NCAC 13G .0202	THE LICENSE	Amended Eff. July 1, 2005	Necessary with substantive public interest	No		Select One	Select One	Select One	Select One	Select One
Ø		10A NCAC 13G .0203	PERSONS NOT ELIGIBLE FOR NEW ADULT CARE HOME LICENSES	Eff. July 1, 2000	Unnecessary	No		Select One	Select One	Select One	Select One	Select One
*		10A NCAC 13G .0204	APPLYING FOR A LICENSE TO OPERATE A HOME NOT CURRENTLY LICENSED	Amended Eff. July 1, 2005	Necessary with substantive public interest	No		Select One	Select One	Select One	Select One	Select One
*		10A NCAC 13G .0206	CAPACITY	Amended Eff. July 1, 2005	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
*		10A NCAC 13G .0207	CHANGE OF LICENSEE	Amended Eff. June 1, 2004	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
		10A NCAC 13G .0208	RENEWAL OF LICENSE	Amended Eff. July 1, 2000	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
*		10A NCAC 13G .0209	CONDITIONS FOR LICENSE RENEWAL	Eff. July 1, 2000	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
		10A NCAC 13G .0211	CLOSING OF HOME	Amended Eff. June 1, 2004	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
*		10A NCAC 13G .0212	DENIAL AND REVOCATION OF LICENSE	Amended Eff. April 1, 1999	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
*		10A NCAC 13G .0213	APPEAL OF LICENSURE ACTION	Amended Eff. July 1, 1990	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
*		10A NCAC 13G .0214	SUSPENSION OF ADMISSIONS	Amended Eff. July 1, 1990	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
Ø		10A NCAC 13G .0215	APPEAL OF SUSPENSION OF ADMISSIONS	Amended Eff. January 4, 1994	Unnecessary	No		Select One	Unnecessary	Select One	Unnecessary and should expire on the first day of the month following the consultation	Select One
*	SECTION .0300 - THE BUILDING	10A NCAC 13G .0301	APPLICATION OF PHYSICAL PLANT REQUIREMENTS	Eff. July 1, 2005	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
*		10A NCAC 13G .0302	DESIGN AND CONSTRUCTION	Amended Eff. July 1, 2005	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
		10A NCAC 13G .0303	LOCATION	Recodified from 10A NCAC 13G .0301 Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One

G.S. 150B-21.3A Report for Subchapter 13G, LICENSING OF FAMILY CARE HOMES

Agency - Medical Care Commission

Comment Period - 5/25/18 - 7/24/18

Date Submitted to APO - Filled in by RRC staff

Subchapter	Rule Section	Rule Citation	Rule Name	Date and Last Agency Action on the Rule	Agency Determination [150B-21.3A(c)(1)a]	Implements or Conforms to Federal Regulation [150B-21.3A(e)]	Federal Regulation Citation	Public Comment Received [150B-21.3A(c)(1)]	Agency Determination Following Public Comment [150B-21.3A(c)(1)]	RRC Determination of Public Comments [150B-21.3A(c)(2)]	RRC Final Determination of Status of Rule for Report to APO [150B-21.3A(c)(2)]	OAH Next Steps
		10A NCAC 13G .0304	LIVING ARRANGEMENT	Recodified from 10A NCAC 13G .0303 Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .0305	LIVING ROOM	Recodified from 10A NCAC 13G .0304 Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .0306	DINING ROOM	Recodified from 10A NCAC 13G .0305 Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
X		10A NCAC 13G .0307	KITCHEN	Recodified from 10A NCAC 13G .0306 Eff. July 1, 2005	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
		10A NCAC 13G .0308	BEDROOMS	Recodified from 10A NCAC 13G .0307 Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .0309	BATHROOM	Recodified from 10A NCAC 13G .0308 Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .0310	STORAGE AREAS	Recodified from 10A NCAC 13G .0309 Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .0311	CORRIDOR	Recodified from 10A NCAC 13G .0310 Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
X		10A NCAC 13G .0312	OUTSIDE ENTRANCE AND EXITS	Recodified from 10A NCAC 13G .0311 Eff. July 1, 2005	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
		10A NCAC 13G .0313	LAUNDRY ROOM	Recodified from 10A NCAC 13G .0312 Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .0314	FLOORS	Recodified from 10A NCAC 13G .0313 Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
X		10A NCAC 13G .0315	HOUSEKEEPING AND FURNISHINGS	Recodified from 10A NCAC 13G .0314 Eff. July 1, 2005	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
		10A NCAC 13G .0316	FIRE SAFETY AND DISASTER PLAN	Recodified from 10A NCAC 13G .0315 Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .0317	BUILDING SERVICE EQUIPMENT	Recodified from 10A NCAC 13G .0316 Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .0318	OUTSIDE PREMISES	Recodified from 10A NCAC 13G .0317 Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
X	SECTION .0400 - STAFF QUALIFICATIONS	10A NCAC 13G .0402	QUALIFICATIONS OF SUPERVISOR-IN-CHARGE	Amended Eff. August 1, 1991	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One

G.S. 150B-21.3A Report for Subchapter 13G, LICENSING OF FAMILY CARE HOMES

Agency - Medical Care Commission

Comment Period - 5/25/18 - 7/24/18

Date Submitted to APO - Filled in by RRC staff

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X		10A NCAC 13G .0403	QUALIFICATIONS OF MEDICATION STAFF	Amended Eff. July 1, 2005	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
X		10A NCAC 13G .0404	QUALIFICATIONS OF ACTIVITY DIRECTOR	Amended Eff. July 1, 2005	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
X		10A NCAC 13G .0405	TEST FOR TUBERCULOSIS	Amended Eff. June 1, 2004	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
X		10A NCAC 13G .0406	OTHER STAFF QUALIFICATIONS	Amended Eff. June 1, 2004	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
Ø		10A NCAC 13G .0407	FISCAL QUALIFICATIONS	Eff. July 1, 1990	Unnecessary	No		Select One	Unnecessary	Select One	Unnecessary and should expire on the first day of the month following the consultation	Select One
X	SECTION .0500 – STAFF ORIENTATION, TRAINING, COMPETENCY AND CONTINUING EDUCATION	10A NCAC 13G .0501	PERSONAL CARE TRAINING AND COMPETENCY	Amended Eff. July 1, 2000	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
X		10A NCAC 13G .0502	PERSONAL CARE TRAINING AND COMPETENCY PROGRAM APPROVAL	Amended Eff. July 1, 2000	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
X		10A NCAC 13G .0503	MEDICATION ADMINISTRATION COMPETENCY EVALUATION	Eff. July 1, 2000	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
X		10A NCAC 13G .0504	COMPETENCY VALIDATION FOR LICENSED HEALTH PROFESSIONAL SUPPORT	Eff. July 1, 2004	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
		10A NCAC 13G .0505	TRAINING ON CARE OF DIABETIC RESIDENTS	Eff. June 1, 2004	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .0506	TRAINING ON PHYSICAL RESTRAINTS	Eff. June 1, 2004	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
X		10A NCAC 13G .0507	TRAINING ON CARDIO-PULMONARY RESUSCITATION	Eff. July 1, 2004	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
X		10A NCAC 13G .0508	ASSESSMENT TRAINING	Eff. June 1, 2004	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
X		10A NCAC 13G .0509	FOOD SERVICE ORIENTATION	Eff. June 1, 2005	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
		10A NCAC 13G .0512	DOCUMENTATION OF TRAINING AND COMPETENCY VALIDATION	Eff. June 1, 2004	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One

G.S. 150B-21.3A Report for Subchapter 13G, LICENSING OF FAMILY CARE HOMES

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Subchapter	Rule Section	Rule Citation	Rule Name	Date and Last Agency Action on the Rule	Agency Determination [150B-21.3A(c)(1)a]	Implements or Conforms to Federal Regulation [150B-21.3A(e)]	Federal Regulation Citation	Public Comment Received [150B-21.3A(c)(1)]	Agency Determination Following Public Comment [150B-21.3A(c)(1)]	RRC Determination of Public Comments [150B-21.3A(c)(2)]	RRC Final Determination of Status of Rule for Report to APO [150B-21.3A(c)(2)]	OAH Next Steps
X	SECTION .0600 -- STAFFING OF THE HOME	10A NCAC 13G .0601	MANAGEMENT AND OTHER STAFF	Amended Eff. July 1, 2005	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
0		10A NCAC 13G .0602	THE CO-ADMINISTRATOR	Amended Eff. April 1, 1984	Unnecessary	No		Select One	Unnecessary	Select One	Unnecessary and should expire on the first day of the month following the consultation	Select One
	SECTION .0700 -- ADMISSION AND DISCHARGE	10A NCAC 13G .0701	ADMISSION OF RESIDENTS	Amended Eff. February 1, 1993	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
X		10A NCAC 13G .0702	TUBERCULOSIS TEST AND MEDICAL EXAMINATION	Amended Eff. June 1, 2004	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
X		10A NCAC 13G .0703	RESIDENT REGISTER	Amended Eff. July 1, 2005	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
X		10A NCAC 13G .0704	RESIDENT CONTRACT AND INFORMATION ON HOME	Amended Eff. July 1, 2005	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
X		10A NCAC 13G .0705	DISCHARGE OF RESIDENTS	Amended Eff. July 1, 2004	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
X	SECTION .0800 -- RESIDENT ASSESSMENT AND CARE PLAN	10A NCAC 13G .0801	RESIDENT ASSESSMENT	Amended Eff. July 1, 2005	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
X		10A NCAC 13G .0802	RESIDENT CARE PLAN	Amended Eff. July 1, 2005	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
	SECTION .0900 -- RESIDENT CARE AND SERVICES	10A NCAC 13G .0901	PERSONAL CARE AND SUPERVISION	Amended Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .0902	HEALTH CARE	Amended Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
X		10A NCAC 13G .0903	LICENSED HEALTH PROFESSIONAL SUPPORT	Amended Eff. June 1, 2004	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
X		10A NCAC 13G .0904	NUTRITION AND FOOD SERVICE	Amended Eff. June 1, 2004	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
		10A NCAC 13G .0905	ACTIVITIES PROGRAM	Amended Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .0906	OTHER RESIDENT SERVICES	Amended Eff. December 1, 1991	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .0907	RESPIRE CARE	Amended Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One

G.S. 150B-21.3A Report for Subchapter 13G, LICENSING OF FAMILY CARE HOMES

Agency - Medical Care Commission

Comment Period - 5/25/18 - 7/24/18

Date Submitted to APO - Filed in by RRC Staff

Subchapter	Rule Section	Rule Citation	Rule Name	Date and Last Agency Action on the Rule	Agency Determination [150B-21.3A(c)(1)a]	Implements or Conforms to Federal Regulation [150B-21.3A(e)]	Federal Regulation Citation	Public Comment Received [150B-21.3A(c)(1)]	Agency Determination Following Public Comment [150B-21.3A(c)(1)]	RRC Determination of Public Comments [150B-21.3A(c)(2)]	RRC Final Determination of Status of Rule for Report to APO [150B-21.3A(c)(2)]	OAH Next Steps
⊙		10A NCAC 13G .0908	COOPERATION WITH CASE MANAGERS	Eff. May 1, 1997	Unnecessary	No		Select One	Unnecessary	Select One	Unnecessary and should expire on the first day of the month following the consultation	Select One
		10A NCAC 13G .0909	RESIDENT RIGHTS	Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
	SECTION .1000 - MEDICATIONS	10A NCAC 13G .1001	MEDICATION ADMINISTRATION POLICIES AND PROCEDURES	Amended Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .1002	MEDICATION ORDERS	Amended Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .1003	MEDICATION LABELS	Amended Eff. April 1, 2015	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .1004	MEDICATION ADMINISTRATION	Amended Eff. July 1, 2005	Necessary without substantive public interest	Select One		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .1005	SELF-ADMINISTRATION OF MEDICATIONS	Eff. July 1, 2000	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
✱		10A NCAC 13G .1006	MEDICATION STORAGE	Eff. July 1, 2000	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
		10A NCAC 13G .1007	MEDICATION DISPOSITION	Eff. July 1, 2000	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .1008	CONTROLLED SUBSTANCES	Amended Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .1009	PHARMACEUTICAL CARE	Eff. July 1, 2000	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .1010	PHARMACEUTICAL SERVICES	Amended Eff. April 1, 2015	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
	SECTION .1100 - MANAGEMENT OF RESIDENT'S FUNDS AND REFUNDS	10A NCAC 13G .1101	MANAGEMENT OF RESIDENT'S FUNDS	Amended Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .1102	LEGAL REPRESENTATIVE OR PAYEE	Amended Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .1103	ACCOUNTING FOR RESIDENT'S PERSONAL FUNDS	Amended Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .1104	REFUND POLICY	Amended Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One

G.S. 150B-21.3A Report for Subchapter 13G, LICENSING OF FAMILY CARE HOMES

Agency - Medical Care Commission

Comment Period - 5/25/18 - 7/24/18

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Subchapter	Rule Section	Rule Citation	Rule Name	Date and Last Agency Action on the Rule	Agency Determination [150B-21.3A(c)(1)a]	Implements or Conforms to Federal Regulation [150B-21.3A(e)]	Federal Regulation Citation	Public Comment Received [150B-21.3A(c)(1)]	Agency Determination Following Public Comment [150B-21.3A(c)(1)]	RRC Determination of Public Comments [150B-21.3A(c)(2)]	RRC Final Determination of Status of Rule for Report to APO [150B-21.3A(c)(2)]	OAH Next Steps
		10A NCAC 13G .1105	REFUND OF PERSONAL FUNDS	Amended Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .1106	SETTLEMENT OF COST OF CARE	Amended Eff. July 1, 2005	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
	SECTION .1200 - POLICIES, RECORDS AND REPORTS	10A NCAC 13G .1201	RESIDENT RECORDS	Amended Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .1202	TRANSFER OF RESIDENT'S RECORDS	Amended Eff. July 1, 1990	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .1203	DISPOSAL OF RESIDENT'S RECORDS	Amended Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .1206	HEALTH CARE PERSONNEL REGISTRY	Eff. July 1, 2000	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .1207	ADVERTISING	Amended Eff. April 1, 1984	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
		10A NCAC 13G .1208	FACILITIES TO REPORT RESIDENT DEATHS	Eff. July 18, 2002	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
		10A NCAC 13G .1209	DEATH REPORTING PROCEDURES	Eff. July 18, 2002	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .1210	DEFINITIONS APPLICABLE TO DEATH REPORTING	Eff. July 18, 2002	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .1211	WRITTEN POLICIES AND PROCEDURES	Eff. June 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .1212	RECORD OF STAFF QUALIFICATIONS	Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .1213	REPORTING OF ACCIDENTS AND INCIDENTS	Eff. July 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
		10A NCAC 13G .1214	AVAILABILITY OF CORRECTIVE ACTION AND SURVEY REPORTS	Eff. July 1, 2005	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
	SECTION .1300 - USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES	10A NCAC 13G .1301	USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES	Eff. June 1, 2005	Necessary without substantive public interest	No		Select One	Necessary without substantive public interest	Select One	Necessary without substantive public interest and should remain in effect without further action	Select One
	SECTION .1600 - RATED CERTIFICATES	10A NCAC 13G .1601	SCOPE	Eff. July 3, 2008	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One

G.S. 150B-21.3A Report for Subchapter 13G, LICENSING OF FAMILY CARE HOMES

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X		10A NCAC 13G .1602	ISSUANCE OF RATED CERTIFICATES	Eff. July 3, 2008	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
X		10A NCAC 13G .1603	STATUTORY AND RULE REQUIREMENTS AFFECTING RATED CERTIFICATES	Eff. July 3, 2008	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
X		10A NCAC 13G .1604	RATING CALCULATION	Eff. July 3, 2008	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One
X		10A NCAC 13G .1605	CONTENTS OF RATED CERTIFICATE	Eff. July 3, 2008	Necessary with substantive public interest	No		Select One	Necessary with substantive public interest	Select One	Necessary with substantive public interest and must be readopted	Select One

SUBCHAPTER 13G – LICENSING OF FAMILY CARE HOMES

SECTION .0100 - DEFINITIONS

10A NCAC 13G .0101 DEFINITIONS

*History Note: Authority G.S. 131D-2; 143B-153;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1987; April 1, 1984; June 26, 1980;
Repealed Eff. July 1, 2005.*

SECTION .0200 - LICENSING

10A NCAC 13G .0201 DEFINITIONS

The following definitions shall apply throughout this Section:

- (1) "Person" means an individual; a trust or estate; a partnership; a corporation; or any grouping of individuals, each of whom owns five percent or more of a partnership or corporation, who collectively own a majority interest of either a partnership or a corporation.
- (2) "Owner" means any person who has or had legal or equitable title to or a majority interest in an adult care home.
- (3) "Affiliate" means any person that directly or indirectly controls or did control an adult care home or any person who is controlled by a person who controls or did control an adult care home. In addition, two or more adult care homes who are under common control are affiliates.
- (4) "Principal" means any person who is or was the owner or operator of an adult care home, an executive officer of a corporation that does or did own or operate an adult care home, a general partner of a partnership that does or did own or operate an adult care home, or a sole proprietorship that does or did own or operate an adult care home.
- (5) "Indirect control" means any situation where one person is in a position to act through another person over whom the first person has control due to the legal or economic relationship between the two.

*History Note: Authority G.S. 131D-2.4; 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000.*

10A NCAC 13G .0202 THE LICENSE

- (a) Except as otherwise provided in Rule .0203 of this Subchapter, the Department of Health and Human Services shall issue a family care home license to any person who submits an application on the forms provided by the Department with a non-refundable license fee as required by G.S. 131D-2(b)(1) and the Department determines that the applicant complies with the provisions of all applicable State family care home licensure statutes and rules. All applications for a new license shall disclose the names of individuals who are co-owners, partners or shareholders holding an ownership or controlling interest of five percent or more of the applicant entity.
- (b) The license shall be conspicuously posted in a public place in the home.
- (c) The license shall be in effect for 12 months from the date of issuance unless revoked for cause, voluntarily or involuntarily terminated, or changed to provisional licensure status.
- (d) A provisional license may be issued in accordance with G.S. 131D-2(b).
- (e) When a provisional license is issued, the administrator shall post the provisional license and a copy of the notice from the Division of Health Service Regulation identifying the reasons for it, in place of the full license.
- (f) The license is not transferable or assignable.
- (g) The license shall be terminated when the home is licensed to provide a higher level of care or a combination of a higher level of care and family care home level of care.

*History Note: Authority G.S. 131D-2.4; 131D-2.7; 131D-2.16; 131D-4.5; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;*

Temporary Amendment Eff. January 1, 1998;
Amended Eff. April 1, 1999;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005.

10A NCAC 13G .0203 PERSONS NOT ELIGIBLE FOR NEW ADULT CARE HOME LICENSES

- (a) A new license shall not be issued for an adult care home if any of the conditions specified in G.S. 131D-2(b)(1b) apply to the applicant for the adult care home license.
- (b) Additionally, no new license shall be issued for any adult care home to an applicant for licensure who is the owner, principal or affiliate of an adult care home that has had its admissions suspended until six months after the suspension is lifted.

History Note: Authority G.S. 131D-2.4; 131D-2.5; 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000.

10A NCAC 13G .0204 APPLYING FOR A LICENSE TO OPERATE A HOME NOT CURRENTLY LICENSED

- (a) An application for a license to operate a family care home for adults in an existing building where no alterations are necessary or a home which is to be constructed, added to or renovated shall be made at the county department of social services.
- (b) If during the study of the administrator and the home, it does not appear that the qualifications of the administrator or requirements for the home can be met, the county department of social services shall so inform the applicant, indicating in writing the reason and give the applicant an opportunity to withdraw the application. Upon the applicant's request, the application shall be completed and submitted to the Division of Health Service Regulation for consideration.
- (c) The applicant shall submit the following forms and reports through the county department of social services to the Division of Health Service Regulation:
 - (1) the Initial Licensure Application;
 - (2) an approval letter from the local zoning jurisdiction for the proposed location;
 - (3) a photograph of each side of the existing structure and at least one of each of the interior spaces if an existing structure;
 - (4) a set of blueprints or a floor plan of each level indicating the layout of all rooms, room dimensions (including closets), door widths (exterior, bedroom, bathroom and kitchen doors), window sizes and window sill heights, type of construction, the use of the basement and attic, the proposed resident bedroom locations including the number of occupants and the bedroom and number (including the ages) of any non-resident who will be residing within the home;
 - (5) a cover letter or transmittal form prepared by the adult home specialist of the county department of social services identifying the prospective home site address, the name of the contact person (including address, telephone numbers, fax numbers), the name and address of the applicant (if different from the contact person) and the total number and the expected evacuation capability of the residents; and
- (6) a construction review fee according to G.S. 131E-267.
- (d) The Construction Section of the Division of Health Service Regulation shall review the information and notify the applicant and the county department of social services of any required changes that must be made to the building to meet the rules in Section .0300 of this Subchapter along with the North Carolina State Building Code. At the end of the letter there shall be a list of final documentation required from the local jurisdiction that must be submitted upon completion of any required changes to the building or completion of construction.
- (e) Any changes to be made during construction that were not proposed during the initial review shall require the approval of the Construction Section to assure that licensing requirements are maintained.
- (f) Upon receipt of the required final documentation from the local jurisdiction, the Construction Section shall review the information and may either make an on-site visit or approve the home for construction by documentation. If all items are met, the Construction Section shall notify the Adult Care Licensure Section of the Division of Health Service Regulation of its recommendation for licensure.

(g) Following review of the application, references, all forms and the Construction Section's recommendation for licensure, a pre-licensing visit shall be made by a consultant of the Adult Care Licensure Section. The consultant shall report findings and recommendations to the Division of Health Service Regulation which shall notify, in writing, the applicant and the county department of social services of the decision to license or not to license the family care home.

History Note: Authority G.S. 131D-2.4; 131D-2.5; 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1987; April 1, 1984;
ARRC Objection Lodged November 14, 1990;
Amended Eff. May 1, 1991;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. July 1, 2005; July 1, 2004.

10A NCAC 13G .0205 APPLICATION TO LICENSE A NEWLY CONSTRUCTED OR RENOVATED BUILDING

History Note: Authority G.S. 131D-2; 143B-165; S.L. 2002-0160;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1984;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004;
Repealed Eff. July 1, 2005.

10A NCAC 13G .0206 CAPACITY

- (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents.
- (b) The total number of residents shall not exceed the number shown on the license.
- (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Health Service Regulation, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure.
- (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations.
- (e) The licensee or the licensee's designee shall notify the Division of Health Service Regulation if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Health Service Regulation for review of any possible changes that may be required to the building.

History Note: Authority G.S. 131D-2.4; 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; July 1, 1990; April 1, 1984; January 1, 1983.

10A NCAC 13G .0207 CHANGE OF LICENSEE

When a licensee wishes to sell or lease the family care home business, the following procedure is required:

- (1) The licensee shall notify the county department of social services that a change is desired. When there is a plan for a change of licensee and another person applies to operate the home immediately, the licensee shall notify the county department and the residents or their responsible persons. The county department shall talk with the residents, giving them the opportunity to make other plans if they so desire.

- (2) The county department of social services shall submit all forms and reports specified in Rule .0204 (b) of this Subchapter to the Division of Health Service Regulation.
- (3) The Division of Health Service Regulation shall review the records of the facility and may visit the home.
- (4) The licensee and prospective licensee shall be advised by the Division of Health Service Regulation of any changes which must be made to the building before licensing to a new licensee can be recommended.
- (5) Frame or brick veneer buildings over one story in height with resident services and accommodations on the second floor shall not be considered for re-licensure.

*History Note: Authority G.S. 131D-2.4; 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1984;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004.*

10A NCAC 13G .0208 RENEWAL OF LICENSE

- (a) The license shall be renewed annually, except as otherwise provided in Rule .0209 of this Subchapter, if the licensee submits an application for renewal on the forms provided by the Department and the Department determines that the licensee complies with the provisions of all applicable State adult care home licensure statutes and rules. When violations of licensure rules or statutes are documented and have not been corrected prior to expiration of license, the Department may approve a continuation or extension of a plan of correction, or may issue a provisional license or revoke the license for cause.
- (b) All applications for license renewal shall disclose the names of individuals who are co-owners, partners or shareholders holding an ownership or controlling interest of 5% or more of the applicant entity.

*History Note: Authority G.S. 131D-2.4; 131D-2.16; 131D-4.5; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. December 1, 1992; July 1, 1990; April 1, 1987; April 1, 1984;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000.*

10A NCAC 13G .0209 CONDITIONS FOR LICENSE RENEWAL

- (a) Before renewing an existing license of an adult care home, the Department shall conduct a compliance history review of the facility and its principals and affiliates.
- (b) In determining whether to renew a license under G.S. 131D-2(b)(6), the Department shall take into consideration at least the following:
 - (1) the compliance history of the applicant facility;
 - (2) the compliance history of the owners, principals or affiliates in operating other adult care homes in the state;
 - (3) the extent to which the conduct of a related facility is likely to affect the quality of care at the applicant facility; and
 - (4) the hardship on residents of the applicant facility if the license is not renewed.
- (c) Pursuant to G.S. 131D-2(b)(1), an adult care home is not eligible to have its license renewed if any outstanding fines or penalties imposed by the Department have not been paid; provided, however that if an appeal is pending the fine or penalty will not be considered imposed until the appeal is resolved.

*History Note: Authority G.S. 131D-2.4; 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000.*

10A NCAC 13G .0210 TERMINATION OF LICENSE

History Note: Authority G.S. 131D-2; 143B-153;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1984;
Temporary Amendment Eff. January 1, 1998;
Amended Eff. April 1, 1999;
Repealed Eff. July 1, 2005.

10A NCAC 13G .0211 CLOSING OF HOME

If a licensee plans to close a family care home, the licensee shall provide written notification of the planned closing to the Division of Health Service Regulation, the county department of social services and the residents or their responsible persons at least 30 days prior to the planned closing. Written notification shall include date of closing and plans made for the move of the residents.

History Note: Authority G.S. 131D-2.4; 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1984;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004.

10A NCAC 13G .0212 DENIAL AND REVOCATION OF LICENSE

- (a) A license may be denied by the Division of Health Service Regulation for failure to comply with the rules of this Subchapter.
- (b) Denial by the Division of Health Service Regulation shall be effected by mailing to the applicant, by registered mail, a notice setting forth the particular reasons for such action.
- (c) A license may be revoked by the Division of Health Service Regulation in accordance with G.S. 131D-2(b) and G.S. 131D-29.
- (d) When a facility receives a notice of revocation, the administrator shall inform each resident and his responsible person of the notice and the basis on which it was issued.

History Note: Authority G.S. 131D-2.7; 131D-2.16; 131D-4.3; 131D-29; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984; May 1, 1981;
Temporary Amendment Eff. January 1, 1998;
Amended Eff. April 1, 1999.

10A NCAC 13G .0213 APPEAL OF LICENSURE ACTION

- (a) In accordance with G.S. 150B-2(2), any person may request a determination of his legal rights, privileges, or duties as they relate to laws or rules administered by the Department of Human Resources. All requests must be in writing and contain a statement of facts prompting the request sufficient to allow for appropriate processing by the Department of Health and Human Services.
- (b) Any person seeking such a determination shall comply with G.S. 150B-22 concerning informal remedies.
- (c) All petitions for hearings regarding matters under the control of the Department of Health and Human Services shall be filed with the Office of Administrative Hearings in accordance with G.S. 150B-23 and 26 NCAC 03 .0103. In accordance with G.S. 1A-1, Rule 4(j)4, the petition shall be served on a registered agent for service of process for the Department of Health and Human Services. A list of registered agents may be obtained from the Office of Legislative and Legal Affairs at 2005 Mail Service Center, Raleigh, North Carolina 27699-2005.
- (d) An administrator of a facility which has its license revoked may not apply to operate another facility except according to the terms set forth by the Director of the Division of Health Service Regulation in his final closure notice.

History Note: Authority 131D-2.4; 131D-2.16; 143B-165; 150B-23;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;

Amended Eff. July 1, 1990; April 1, 1984.

10A NCAC 13G .0214 SUSPENSION OF ADMISSIONS

(a) Either the Secretary or his designee shall notify the domiciliary home by certified mail of the decision to suspend admissions. Such notice will include:

- (1) the period of the suspension,
- (2) factual allegations,
- (3) citation of statutes and rules alleged to be violated,
- (4) notice of the facility's right to contested case hearing or the suspension.

(b) The suspension will be effective when the notice is served or on the date specified in the notice of suspension, whichever is later. The suspension will remain effective for the period specified in the notice or until the facility demonstrates to the Secretary or his designee that conditions are no longer detrimental to the health and safety of the residents.

(c) The home shall not admit new residents during the effective date of the suspension.

(d) Any action taken by the Division of Health Service Regulation to revoke a home's license or to reduce the license to a provisional license shall be accompanied by a recommendation to the Secretary or his designee to suspend new admissions. A suspension may be ordered without the license being affected.

*History Note: Authority G.S. 131D-2.7;
Eff. January 1, 1982;
Amended Eff. July 1, 1990.*

10A NCAC 13G .0215 APPEAL OF SUSPENSION OF ADMISSIONS

A home may appeal the decision of the Secretary or his designee to suspend new admissions by making such an appeal in accordance with 10A NCAC 01A .0200.

*History Note: Authority G.S. 131D-2.7;
Eff. January 1, 1982;
Amended Eff. January 4, 1994.*

10A NCAC 13G .0216 ADMINISTRATIVE PENALTY DETERMINATION PROCESS

*History Note: Authority G.S. 131D-34;
Eff. December 1, 1992;
Amended Eff. March 1, 1995; December 1, 1993;
Temporary Amendment Eff. December 8, 1997;
Amended Eff. April 1, 1999;
Repealed Eff. October 1, 2016.*

SECTION .0300 - THE BUILDING

10A NCAC 13G .0301 APPLICATION OF PHYSICAL PLANT REQUIREMENTS

The physical plant requirements for each family care home shall be applied as follows:

- (1) New construction and existing buildings proposed for use as a Family Care Home shall comply with the requirements of this Section;
- (2) Except where otherwise specified, existing licensed homes or portions of existing licensed homes shall meet licensure and code requirements in effect at the time of construction, change in service or bed count, addition, renovation or alteration; however, in no case shall the requirements for any licensed home, where no addition or renovation has been made, be less than those requirements found in the 1971 "Minimum and Desired Standards and Regulations" for "Family Care Homes", copies of which are available at the Division of Health Service Regulation, 701 Barbour Drive, Raleigh, North Carolina 27603 at no cost;
- (3) New additions, alterations, modifications and repairs shall meet the requirements of this Section;
- (4) Rules contained in this Section 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 shall be approved by the Division when the home 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 home; and
- (6) Where rules, codes or standards have any conflict, the most stringent requirement shall apply.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. July 1, 2005.*

10A NCAC 13G .0302 DESIGN AND CONSTRUCTION

- (a) Any building licensed for the first time as a family care home shall meet the applicable requirements of the North Carolina State Building Code. All new construction, additions and renovations to existing buildings shall meet the requirements of the North Carolina State Building Code for One and Two Family Dwellings and Residential Care Facilities if applicable. All applicable volumes of The North Carolina State Building Code, which is incorporated by reference, including all subsequent amendments, may be purchased from the Department of Insurance Engineering Division located at 322 Chapanoke Road, Suite 200, Raleigh, North Carolina 27603 at a cost of three hundred eighty dollars (\$380.00).
- (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home.
- (c) Any existing building converted from another use to a family care home shall meet all the requirements of a new facility.
- (d) Any existing licensed home when the license is terminated for more than 60 days shall meet all requirements of a new home prior to being relicensed.
- (e) Any existing licensed home that plans to have new construction, remodeling or physical changes done to the facility shall have drawings submitted by the owner or his appointed representative to the Division of Health Service Regulation for review and approval prior to commencement of the work.
- (f) If the building is two stories in height, it shall meet the following requirements:
 - (1) Each floor shall be less than 2500 square feet in area if existing construction or, if new construction, shall not exceed the allowable area for R-4 occupancy in the North Carolina State Building Code;
 - (2) Aged or disabled persons are not to be housed on any floor above or below grade level;
 - (3) Required resident facilities are not to be located on any floor above or below grade level; and
 - (4) A complete fire alarm system with pull stations on each floor and sounding devices which are audible throughout the building shall be provided. The fire alarm system shall be able to transmit an automatic signal to the local emergency fire department dispatch center, either directly or through a central station monitoring company connection.
- (g) The basement and the attic shall not be used for storage or sleeping.
- (h) The ceiling shall be at least seven and one-half feet from the floor.
- (i) In homes licensed on or after April 1, 1984, all required resident areas shall be on the same floor level. Steps between levels are not permitted.
- (j) The door width shall be a minimum of two feet and six inches in the kitchen, dining room, living rooms, bedrooms and bathrooms.
- (k) All windows shall be maintained operable.
- (l) The local code enforcement official shall be consulted before starting any construction or renovations for information on required permits and construction requirements.
- (m) The building shall meet sanitation requirements as determined by the North Carolina Department of Environment and Natural Resources; Division of Environmental Health.
- (n) The home shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1984; January 1, 1983;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. July 1, 2005; June 1, 2004.*

10A NCAC 13G .0303 LOCATION

- (a) A family care home shall be in a location approved by local zoning boards.
- (b) The home shall be located so that hazards to the occupants are minimized.
- (c) The site of the home shall:
 - (1) be accessible by streets, roads and highways and be maintained for motor vehicles and emergency vehicle access;
 - (2) be accessible to fire fighting and other emergency services;
 - (3) have a water supply, sewage disposal system, garbage disposal system and trash disposal system approved by the local health department having jurisdiction;
 - (4) meet all local ordinances; and
 - (5) be free from exposure to pollutants known to the applicant or licensee.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; July 1, 1990; April 1, 1984;
Recodified from 10A NCAC 13G .0301 Eff. July 1, 2005.*

10A NCAC 13G .0304 LIVING ARRANGEMENT

A family care home shall provide living arrangements to meet the individual needs of the residents, the live-in staff and other live-in persons.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 1984;
Recodified from 10A NCAC 13G .0303 Eff. July 1, 2005.*

10A NCAC 13G .0305 LIVING ROOM

- (a) Family care homes licensed on or after April 1, 1984 shall have a living room area of at least 200 square feet.
- (b) All living rooms shall have operable windows to meet the North Carolina State Building Code and be lighted to provide 30 foot candles of light at floor level.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; July 1, 1990; April 1, 1984;
Recodified from 10A NCAC 13G .0304 Eff. July 1, 2005.*

10A NCAC 13G .0306 DINING ROOM

- (a) Family care homes licensed on or after April 1, 1984 shall have a dining room or area of at least 120 square feet. The dining room may be used for other activities during the day.
- (b) When the dining area is used in combination with a kitchen, an area five feet wide shall be allowed as work space in front of the kitchen work areas. The work space shall not be used as the dining area.
- (c) The dining room shall have operable windows and be lighted to provide 30 foot candles of light at floor level.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; July 1, 1990; April 1, 1984;
Recodified from 10A NCAC 13G .0305 Eff. July 1, 2005.*

10A NCAC 13G .0307 KITCHEN

- (a) The kitchen in a family care home shall be large enough to provide for the preparation and preservation of food and the washing of dishes.

- (b) The cooking unit shall be mechanically ventilated to the outside or be an unvented, recirculating fan provided with any special filter per manufacturers' instructions for ventless use.
- (c) The kitchen floor shall have a non-slippery water-resistant covering.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Amended Eff. April 22, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 1984;
Recodified from 10A NCAC 13G .0306 Eff. July 1, 2005.*

10A NCAC 13G .0308 BEDROOMS

- (a) There shall be bedrooms sufficient in number and size to meet the individual needs according to age and sex of the residents, the administrator or supervisor-in-charge, other live-in staff and any other persons living in a family care home. Residents are not to share bedrooms with staff or other live-in non-residents.
- (b) Only rooms authorized by the Division of Health Service Regulation as bedrooms shall be used for bedrooms.
- (c) A room where access is through a bathroom, kitchen or another bedroom shall not be approved for a resident's bedroom.
- (d) There shall be a minimum area of 100 square feet, excluding vestibule, closet or wardrobe space, in rooms occupied by one person and a minimum area of 80 square feet per bed, excluding vestibule, closet or wardrobe space, in rooms occupied by two persons.
- (e) The total number of residents assigned to a bedroom shall not exceed the number authorized by the Division of Health Service Regulation for that particular bedroom.
- (f) A bedroom shall not be occupied by more than two residents.
- (g) Each resident bedroom must have one or more operable windows and be lighted to provide 30 foot candles of light at floor level. The window area shall be equivalent to at least eight percent of the floor space. The windows shall have a maximum of 44 inch sill height.
- (h) Bedroom closets or wardrobes shall be large enough to provide each resident with a minimum of 48 cubic feet of clothing storage space (approximately two feet deep by three feet wide by eight feet high) of which at least one-half shall be for hanging clothes with an adjustable height hanging bar.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; July 1, 1990; April 1, 1984;
Recodified from 10A NCAC 13G .0307 Eff. July 1, 2005.*

10A NCAC 13G .0309 BATHROOM

- (a) Adult care homes licensed on or after April 1, 1984, shall have one full bathroom for each five or fewer persons including live-in staff and family.
- (b) The bathrooms shall be designed to provide privacy. A bathroom with two or more water closets (commodes) shall have privacy partitions or curtains for each water closet. Each tub or shower shall have privacy partitions or curtains.
- (c) Entrance to the bathroom shall not be through a kitchen, another person's bedroom, or another bathroom.
- (d) The required residents' bathrooms shall be located so that there is no more than 40 feet from any residents' bedroom door to a resident use bathroom door.
- (e) Hand grips shall be installed at all commodes, tubs and showers used by the residents.
- (f) Nonskid surfacing or strips must be installed in showers and bath areas.
- (g) The bathrooms shall be lighted to provide 30 foot candles of light at floor level and have mechanical ventilation at the rate of two cubic feet per minute for each square foot of floor area. These vents shall be vented directly to the outdoors.
- (h) The bathroom floor shall have a non-slippery water-resistant covering.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;*

*Amended Eff. July 1, 2005; July 1, 1990; April 1, 1984;
Recodified from 10A NCAC 13G .0308 Eff. July 1, 2005.*

10A NCAC 13G .0310 STORAGE AREAS

- (a) Storage areas shall be adequate in size and number for separate storage of clean linens, soiled linens, food and food service supplies, and household supplies and equipment.
- (b) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be supervised while in use.

*History Note: Authority G.S. 131D-4.5; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1987; April 1, 1984;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Recodified from 10A NCAC 13G .0309 Eff. July 1, 2005.*

10A NCAC 13G .0311 CORRIDOR

- (a) Corridors shall be a minimum clear width of three feet in family care homes.
- (b) Corridors shall be lighted with night lights providing 1 foot-candle power at the floor.
- (c) Corridors shall be free of all equipment and other obstructions.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 1984;
Recodified from 10A NCAC 13G .0310 Eff. July 1, 2005.*

10A NCAC 13G .0312 OUTSIDE ENTRANCE AND EXITS

- (a) In family care homes, all floor levels shall have at least two exits. If there are only two, the exit or exit access doors shall be so located and constructed to minimize the possibility that both may be blocked by any one fire or other emergency condition.
- (b) At least one entrance/exit door shall be a minimum width of three feet and another shall be a minimum width of two feet and eight inches.
- (c) At least one principal outside entrance/exit for the residents' use shall be at grade level or accessible by ramp with a one inch rise for each 12 inches of length of the ramp. For the purposes of this Rule, a principal outside entrance/exit is one that is most often used by residents for vehicular access. If the home has any resident that must have physical assistance with evacuation, the home shall have two outside entrances/exits at grade level or accessible by a ramp.
- (d) All exit door locks shall be easily operable, by a single hand motion, from the inside at all times without keys. Existing deadbolts or turn buttons on the inside of exit doors shall be removed or disabled.
- (e) All entrances/exits shall be free of all obstructions or impediments to allow for full instant use in case of fire or other emergency.
- (f) All steps, porches, stoops and ramps shall be provided with handrails and guardrails.
- (g) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door for resident use shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the bedroom of the person on call, the office area or in a location accessible only to staff authorized by the administrator to operate the control panel.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 1987; July 1, 1984; April 1, 1984;
Recodified from 10A NCAC 13G .0311 Eff. July 1, 2005.*

10A NCAC 13G .0313 LAUNDRY ROOM

The laundry equipment in a family care home shall be located out of the living, dining, and bedroom areas.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 1984;
Recodified from 10A NCAC 13G .0312 Eff. July 1, 2005.*

10A NCAC 13G .0314 FLOORS

- (a) All floors in a family care home shall be of smooth, non-skid material and so constructed as to be easily cleanable.
- (b) Scatter or throw rugs shall not be used.
- (c) All floors shall be kept in good repair.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 1984;
Recodified from 10A NCAC 13G .0313 Eff. July 1, 2005.*

10A NCAC 13G .0315 HOUSEKEEPING AND FURNISHINGS

- (a) Each family care home shall:
 - (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;
 - (2) have no chronic unpleasant odors;
 - (3) have furniture clean and in good repair;
 - (4) have a North Carolina Division of Environmental Health approved sanitation classification at all times;
 - (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards;
 - (6) have supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times;
 - (7) make available the following items as needed through any means other than charge to the personal funds of recipients of State-County Special Assistance:
 - (A) protective sheets and clean, absorbent, soft and smooth pads;
 - (B) bedpans, urinals, hot water bottles, and ice caps; and
 - (C) bedside commodes, walkers, and wheelchairs;
 - (8) have television and radio, each in good working order;
 - (9) have curtains, draperies or blinds at windows in resident use areas to provide for resident privacy;
 - (10) have recreational equipment, supplies for games, books, magazines and a current newspaper available for residents;
 - (11) have a clock that has numbers at least 1½ inches tall in an area commonly used by the residents; and
 - (12) have at least one telephone that does not depend on electricity or cellular service to operate.
- (b) Each bedroom shall have the following furnishings in good repair and clean for each resident:
 - (1) A bed equipped with box springs and mattress or solid link springs and no-sag innerspring or foam mattress. Hospital bed appropriately equipped shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the home. Each bed is to have the following:
 - (A) at least one pillow with clean pillow case;
 - (B) clean top and bottom sheets on the bed, with bed changed as often as necessary but at least once a week; and
 - (C) clean bedspread and other clean coverings as needed;
 - (2) a bedside type table;
 - (3) chest of drawers or bureau when not provided as built-ins, or a double chest of drawers or double dresser for two residents;
 - (4) a wall or dresser mirror that can be used by each resident;
 - (5) a minimum of one comfortable chair (rocker or straight, arm or without arms, as preferred by resident), high enough from floor for easy rising;
 - (6) additional chairs available, as needed, for use by visitors;

- (7) individual clean towel, wash cloth, and towel bar within bedroom or adjoining bathroom; and
 - (8) a light overhead of bed with a switch within reach of person lying on bed; or a lamp. The light shall provide a minimum of 30 foot-candle power of illumination for reading.
- (c) The living room shall have functional living room furnishings for the comfort of aged and disabled persons, with coverings that are easily cleanable.
- (d) The dining room shall have the following furnishings:
- (1) tables and chairs to seat all residents eating in the dining room; and
 - (2) chairs that are sturdy, non-folding, without rollers unless retractable or on front legs only, and designed to minimize tilting.
- (e) This Rule shall apply to new and existing homes.

*History Note: Authority G.S. 131D-2.16; 143B-165;
 Eff. January 1, 1977;
 Readopted Eff. October 31, 1977;
 Amended Eff. July 1, 2005; September 1, 1987; April 1, 1987; April 1, 1984;
 Recodified from 10A NCAC 13G .0314 Eff. July 1, 2005.*

10A NCAC 13G .0316 FIRE SAFETY AND DISASTER PLAN

- (a) Fire extinguishers shall be provided which meet these minimum requirements in a family care home:
- (1) one five pound or larger (net charge) "A-B-C" type centrally located;
 - (2) one five pound or larger "A-B-C" or CO/2 type located in the kitchen; and
 - (3) any other location as determined by the code enforcement official.
- (b) The building shall be provided with smoke detectors as required by the North Carolina State Building Code and U.L. listed heat detectors connected to a dedicated sounding device located in the attic and basement. These detectors shall be interconnected and be provided with battery backup.
- (c) Any fire safety requirements required by city ordinances or county building inspectors shall be met.
- (d) A written fire evacuation plan (including a diagrammed drawing) which has the approval of the local code enforcement official shall be prepared in large print and posted in a central location on each floor. The plan shall be reviewed with each resident on admission and shall be a part of the orientation for all new staff.
- (e) There shall be at least four rehearsals of the fire evacuation plan each year. Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, staff members present, and a short description of what the rehearsal involved.
- (f) A written disaster plan which has the written approval of, or has been documented as submitted to, the local emergency management agency and the local agency designated to coordinate special needs sheltering during disasters, shall be prepared and updated at least annually and shall be maintained in the home. This written disaster plan requirement shall apply to new and existing homes.

*History Note: Authority G.S. 131D-2.16; 143B-165;
 Eff. January 1, 1977;
 Amended Eff. April 22, 1977;
 Readopted Eff. October 31, 1977;
 Amended Eff. July 1, 2005; July 1, 1990; April 1, 1987; April 1, 1984;
 Recodified from 10A NCAC 13G .0315 Eff. July 1, 2005.*

10A NCAC 13G .0317 BUILDING SERVICE EQUIPMENT

- (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition.
- (b) There shall be a central heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. Built-in electric heaters, if used, shall be installed or protected so as to avoid hazards to residents and room furnishings. Unvented fuel burning room heaters and portable electric heaters are prohibited.
- (c) Air conditioning or at least one fan per resident bedroom and living and dining areas shall be provided when the temperature in the main center corridor exceeds 80 degrees F (26.7 degrees C).
- (d) The hot water tank shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, and laundry. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C).

- (e) All resident areas shall be well lighted for the safety and comfort of the residents. The minimum lighting required is:
 - (1) 30 foot-candle power for reading;
 - (2) 10 foot-candle power for general lighting; and
 - (3) 1 foot-candle power at the floor for corridors at night.
- (f) Where the bedroom of the live-in staff is located in a separate area from residents' bedrooms, an electrically operated call system shall be provided connecting each resident bedroom to the live-in staff bedroom. The resident call system activator shall be such that it can be activated with a single action and remain on until deactivated by staff. The call system activator shall be within reach of resident lying on his bed.
- (g) Fireplaces, fireplace inserts and wood stoves shall be designed or installed so as to avoid a burn hazard to residents. Fireplace inserts and wood stoves must be U.L. listed.
- (h) Gas logs may be installed if they are of the vented type, installed according to the manufacturers' installation instructions, approved through the local building department and protected by a guard or screen to prevent residents and furnishings from burns.
- (i) Alternate methods, procedures, design criteria and functional variations from the requirements of this Rule or other rules in this Section because of extraordinary circumstances, new programs or unusual conditions, shall be approved by the Division when the facility can effectively demonstrate to the Division's satisfaction that the intent of the requirements are met and that the variation does not reduce the safety or operational effectiveness of the facility.
- (j) This Rule shall apply to new and existing family care homes.

*History Note: Authority G.S. 131D-2.16; 143B-165;
 Eff. January 1, 1977;
 Readopted Eff. October 31, 1977;
 Amended Eff. April 1, 1987; April 1, 1984; July 1, 1982;
 Temporary Amendment Eff. December 1, 1999;
 Amended Eff. July 1, 2005; July 1, 2000;
 Recodified from 10A NCAC 13G .0316 Eff. July 1, 2005.*

10A NCAC 13G .0318 OUTSIDE PREMISES

- (a) The outside grounds of new and existing family care homes shall be maintained in a clean and safe condition.
- (b) If the home has a fence around the premises, the fence shall not prevent residents from exiting or entering freely or be hazardous.
- (c) Outdoor stairways and ramps shall be illuminated by no less than five foot candles of light at grade level.

*History Note: Authority G.S. 131D-2.16; 143B-165;
 Eff. April 1, 1984;
 Amended Eff. July 1, 2005; July 1, 1990;
 Recodified from 10A NCAC 13G .0317 Eff. July 1, 2005.*

SECTION .0400 – STAFF QUALIFICATIONS

10A NCAC 13G .0401 QUALIFICATIONS OF ADMINISTRATOR

*History Note: Authority G.S. 131D-2; 143B-153;
 Eff. January 1, 1977;
 Readopted Eff. October 31, 1977;
 Amended Eff. July 1, 1990; September 1, 1987; April 1, 1987; April 1, 1984;
 ARRC Objection Lodged January 18, 1991;
 Amended Eff. August 1, 1991;
 Repealed Eff. April 1, 2017.*

10A NCAC 13G .0402 QUALIFICATIONS OF SUPERVISOR-IN-CHARGE

The supervisor-in-charge is responsible to the administrator for carrying out the program in the home in the absence of the administrator. All of the following requirements must be met:

- (1) The applicant must complete the Application for Supervisor-in-Charge (DSS-1862);

- (2) The qualifications of the administrator and co-administrator referenced in Paragraphs (2), (5), (6), and (7) of Rule .0401 of this Subchapter shall apply to the supervisor-in-charge. The supervisor-in-charge (employed on or after August 1, 1991) must meet a minimum educational requirement by being at least a high school graduate or certified under the GED Program or by passing an alternative examination established by the Department of Health and Human Services. Documentation that these qualifications have been met must be on file in the home prior to employing the supervisor-in-charge;
- (3) The supervisor-in-charge must be willing to work with bonafide inspectors and the monitoring and licensing agencies toward meeting and maintaining the rules of this Subchapter and other legal requirements;
- (4) The supervisor-in-charge must verify that he earns 12 hours a year of continuing education credits related to the management of domiciliary homes and care of aged and disabled persons in accordance with procedures established by the Department of Health and Human Services;
- (5) When there is a break in employment as a supervisor-in-charge of one year or less, the educational qualification under which the person was last employed will apply.

*History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
 Eff. January 1, 1977;
 Readopted Eff. October 31, 1977;
 ARRC Objection June 16, 1988;
 Amended Eff. July 1, 1990; December 1, 1988; April 1, 1987; January 1, 1985;
 ARRC Objection Lodged January 18, 1991;
 Amended Eff. August 1, 1991.*

10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF

- (a) Family care home staff who administer medications, hereafter referred to as medication aides, and staff who directly supervise the administration of medications shall have documentation of successfully completing the clinical skills validation portion of the competency evaluation according to Paragraphs (d) and (e) of Rule .0503 of this Subchapter prior to the administration or supervision of the administration of medications. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement.
- (b) Medication aides and their direct supervisors, except persons authorized by state occupational licensure laws to administer medications, shall successfully pass the written examination within 90 days after successful completion of the clinical skills validation portion of a competency evaluation according to Rule .0503 of this Subchapter.
- (c) Medication aides and staff who directly supervise the administration of medications, except persons authorized by state occupational licensure laws to administer medications, shall complete six hours of continuing education annually related to medication administration.

*History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
 Temporary Adoption Eff. January 1, 2000; December 1, 1999;
 Eff. July 1, 2000;
 Temporary Amendment Eff. July 1, 2004;
 Amended Eff. July 1, 2005.*

10A NCAC 13G .0404 QUALIFICATIONS OF ACTIVITY DIRECTOR

There shall be a designated family care home activity director who meets the following qualifications: qualifications set forth in this Rule.

- (1) The activity director (employed on or after August 1, 1991) shall meet a minimum educational requirement by being at least a high school graduate or certified under the GED Program or by passing an alternative examination established by the Department of Health & Human Services.
- (2) The activity director hired on or after July 1, 2005 shall have completed or complete, within nine months of employment or assignment to this position, the basic activity course for assisted living activity directors offered by community colleges or a comparable activity course as determined by the Department based on instructional hours and content. A person with a degree in recreation administration or therapeutic recreation or who is state or nationally certified as a Therapeutic Recreation Specialist or certified by the National Certification Council for Activity Professionals meets

this requirement as does a person who completed the activity coordinator course of 48 hours or more through a community college before July 1, 2005.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. April 1, 1984;
Amended Eff. July 1, 1990; April 1, 1987; January 1, 1985;
ARRC Objection Lodged March 18, 1991;
Amended Eff. August 1, 1991;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005.

10A NCAC 13G .0405 TEST FOR TUBERCULOSIS

(a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902.

(b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. January 1, 1977;
Amended Eff. October 1, 1977; April 22, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. December 1, 1993; April 1, 1984;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004.

10A NCAC 13G .0406 OTHER STAFF QUALIFICATIONS

(a) Each staff person of a family care home shall:

- (1) have a job description that reflects actual duties and responsibilities and is signed by the administrator and the employee;
- (2) be able to apply all of the home's accident, fire safety and emergency procedures for the protection of the residents;
- (3) be informed of the confidential nature of resident information and shall protect and preserve such information from unauthorized use and disclosure;
Note: G.S. 131D-2(b)(4), G.S. 131D-21(6), and G.S. 131D-21.1 govern the disclosure of such information;
- (4) not hinder or interfere with the exercise of the rights guaranteed under the Declaration of Residents' Rights in G.S. 131D-21;
- (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;
- (6) have documented annual immunization against influenza virus according to G.S. 131D-9, except as documented otherwise according to exceptions in this law.
- (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40;
- (8) maintain a valid driver's license if responsible for transportation of residents; and
- (9) be willing to work with bona fide inspectors and the monitoring and licensing agencies toward meeting and maintaining the rules of this Subchapter.

(b) Any staff member left in charge of the care of residents shall be 18 years or older.

(c) If licensed practical nurses are employed by the facility and practicing in their licensed capacity as governed by their practice act and occupational licensing laws, there shall be continuous availability of a registered nurse consistent with Rules 21 NCAC 36 .0224(i) and 21 NCAC 36 .0225.

Note: The practice of licensed practical nurses is governed by their occupational licensing laws.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;

Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004.

10A NCAC 13G .0407 FISCAL QUALIFICATIONS

The administrator or corporation must be able to obtain credit or have other verified resources to meet operating costs and provide required services when unexpected situations arise, such as extended resident vacancies and major home repairs. Verification of ability to obtain credit or the availability of other resources must be documented by the administrator or corporation.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. July 1, 1990.

SECTION .0500 – STAFF ORIENTATION, TRAINING, COMPETENCY AND CONTINUING EDUCATION

10A NCAC 13G .0501 PERSONAL CARE TRAINING AND COMPETENCY

(a) The facility shall assure that personal care staff and those who directly supervise them in facilities without heavy care residents successfully complete a 25-hour training program, including competency evaluation, approved by the Department according to Rule .0502 of this Section. For the purposes of this Subchapter, heavy care residents are those for whom the facility is providing personal care tasks listed in Paragraph (i) of this Rule. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties.

(b) The facility shall assure that staff who perform or directly supervise staff who perform personal care tasks listed in Paragraph (i) of this Rule in facilities with heavy care residents successfully complete an 80-hour training program, including competency evaluation, approved by the Department according to Rule .0502 of this Section and comparable to the State-approved Nurse Aide I training.

(c) The facility shall assure that training specified in Paragraphs (a) and (b) of this Rule is successfully completed six months after hiring for staff hired after July 1, 2000. Staff hired prior to July 1, 2000, shall have completed at least a 20-hour training program for the performance or supervision of tasks listed in Paragraph (i) of this Rule or a 75-hour training program for the performance or supervision of tasks listed in Paragraph (j) of this Rule. The 20 and 75-hour training shall meet all the requirements of this Rule except for the interpersonal skills and behavioral interventions listed in Paragraph (j) of this Rule, within six months after hiring.

(d) The Department shall have the authority to extend the six-month time frame specified in Paragraph (c) of this Rule up to six additional months for a maximum allowance of 12 months for completion of training upon submittal of documentation to the Department by the facility showing good cause for not meeting the six-month time frame.

(e) Exemptions from the training requirements of this Rule are as follows:

- (1) The Department shall exempt staff from the 25-hour training requirement upon successful completion of a competency evaluation approved by the Department according to Rule .0502 of this Section if staff have been employed to perform or directly supervise personal care tasks listed in Paragraph (h) and the interpersonal skills and behavioral interventions listed in Paragraph (j) of this Rule in a comparable long-term care setting for a total of at least 12 months during the three years prior to January 1, 1996, or the date they are hired, whichever is later.
- (2) The Department shall exempt staff from the 80-hour training requirement upon successful completion of a 15-hour refresher training and competency evaluation program or a competency evaluation program approved by the Department according to Rule .0502 of this Section if staff have been employed to perform or directly supervise personal care tasks listed in Paragraph (i) and the interpersonal skills and behavioral interventions listed in Paragraph (j) of this Rule in a comparable long-term care setting for a total of at least 12 months during the three years prior to January 1, 1996, or the date they are hired, whichever is later.
- (3) The Department shall exempt staff from the 25 and 80-hour training and competency evaluation who are or have been licensed health professionals or Certified Nursing Assistants.

(f) The facility shall maintain documentation of the training and competency evaluations of staff required by the rules of this Subchapter. The documentation shall be filed in an orderly manner and made available for review by representatives of the Department.

(g) The facility shall assure that staff who perform or directly supervise staff who perform personal care tasks listed in Paragraphs (h) and (i), and the interpersonal skills and behavioral interventions listed in Paragraph (j) of this Rule receive on-the-job training and supervision as necessary for the performance of individual job assignments prior to meeting the training and competency requirements of this Rule.

(h) For the purposes of this Rule, personal care tasks which require a 25-hour training program include, but are not limited to the following:

- (1) assist residents with toileting and maintaining bowel and bladder continence;
- (2) assist residents with mobility and transferring;
- (3) provide care for normal, unbroken skin;
- (4) assist with personal hygiene to include mouth care, hair and scalp grooming, care of fingernails, and bathing in shower, tub, bed basin;
- (5) trim hair;
- (6) shave resident;
- (7) provide basic first aid;
- (8) assist residents with dressing;
- (9) assist with feeding residents with special conditions but no swallowing difficulties;
- (10) assist and encourage physical activity;
- (11) take and record temperature, pulse, respiration, routine height and weight;
- (12) trim toenails for residents without diabetes or peripheral vascular disease;
- (13) perineal care;
- (14) apply condom catheters;
- (15) turn and position;
- (16) collect urine or fecal specimens;
- (17) take and record blood pressure if a registered nurse has determined and documented staff to be competent to perform this task;
- (18) apply and remove or assist with applying and removing prosthetic devices for stable residents if a registered nurse, licensed physical therapist or licensed occupational therapist has determined and documented staff to be competent to perform the task; and
- (19) apply or assist with applying ace bandages, TED's and binders for stable residents if a registered nurse has determined and documented staff to be competent to perform the task.

(i) For the purposes of this Rule, personal care tasks which require a 80-hour training program are as follows:

- (1) assist with feeding residents with swallowing difficulty;
- (2) assist with gait training using assistive devices;
- (3) assist with or perform range of motion exercises;
- (4) empty and record drainage of catheter bag;
- (5) administer enemas;
- (6) bowel and bladder retraining to regain continence;
- (7) test urine or fecal specimens;
- (8) use of physical or mechanical devices attached to or adjacent to the resident which restrict movement or access to one's own body used to restrict movement or enable or enhance functional abilities;
- (9) non-sterile dressing procedures;
- (10) force and restrict fluids;
- (11) apply prescribed heat therapy;
- (12) care for non-infected pressure ulcers; and
- (13) vaginal douches.

(j) For purposes of this Rule, the interpersonal skills and behavioral interventions include, but are not limited to the following:

- (1) recognition of residents' usual patterns of responding to other people;
- (2) individualization of appropriate interpersonal interactions with residents;
- (3) interpersonal distress and behavior problems;
- (4) knowledge of and use of techniques, as alternatives to the use of restraints, to decrease residents' intrapersonal and interpersonal distress and behavior problems; and

- (5) knowledge of procedures for obtaining consultation and assistance regarding safe, humane management of residents' behavioral problems.

*History Note: Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 143B-165;
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000.*

10A NCAC 13G .0502 PERSONAL CARE TRAINING AND COMPETENCY PROGRAM APPROVAL

(a) The 25 hour training specified in Rule .0501 of this Section shall consist of at least 15 hours of classroom instruction, and the remaining hours shall be supervised practical experience. Competency evaluation shall be conducted in each of the following areas:

- (1) personal care skills;
- (2) cognitive, behavioral and social care for all residents and including interventions to reduce behavioral problems for residents with mental disabilities, and;
- (3) residents' rights as established by G.S. 131D-21.

(b) The 80-hour training specified in Rule .0501 of this Section shall consist of at least 34 hours of classroom instruction and at least 34 hours of supervised practical experience. Competency evaluation shall be conducted in each of the following areas:

- (1) observation and documentation;
- (2) basic nursing skills, including special health-related tasks;
- (3) personal care skills;
- (4) cognitive, behavioral and social care for all residents and including interventions to reduce behavioral problems for residents with mental disabilities;
- (5) basic restorative services; and
- (6) residents' rights as established by G.S. 131D-21.

(c) The following requirements shall apply to the 25 and 80-hour training specified in Rule .0501 of this Section:

- (1) The training shall be conducted by an individual or a team of instructors with a coordinator. The supervisor of practical experience and instructor of content having to do with personal care tasks or basic nursing skills shall be a registered nurse with a current, unencumbered license in North Carolina and with two years of clinical or direct patient care experience working in a health care, home care or long term care setting. The program coordinator and any instructor of content that does not include instruction on personal care tasks or basic nursing skills shall be a registered nurse, licensed practical nurse, physician, gerontologist, social worker, psychologist, mental health professional or other health professional with two years of work experience in adult education or in a long term care setting; or a four-year college graduate with four years of experience working in the field of aging or long term care for adults.
- (2) A trainee participating in the classroom instruction and supervised practical experience in the setting of the trainee's employment shall not be considered on duty and counted in the staff-to-resident ratio.
- (3) Training shall not be offered without a qualified instructor on site.
- (4) Classroom instruction shall include the opportunity for demonstration and practice of skills.
- (5) Supervised practical experience shall be conducted in a licensed adult care home or in a facility or laboratory setting comparable to the work setting in which the trainee will be performing or supervising the personal care skills.
- (6) All skills shall be performed on humans except for intimate care skills, such as perineal and catheter care, which may be conducted on a mannequin.
- (7) There shall be no more than 10 trainees for each instructor for the supervised practical experience.
- (8) A written examination prepared by the instructor shall be used to evaluate the trainee's knowledge of the content portion of the classroom training. The trainee shall score at least 70 on the written examination. Oral testing shall be provided in the place of a written examination for trainees lacking reading or writing ability.
- (9) The trainee shall satisfactorily perform all of the personal care skills specified in Rule .0501(h) and the skills specified in 10A NCAC 13G .0401(j) of this Section for the 25-hour training and in Rule .0501(h), (i) and (j) of this Section for the 80-hour training. The instructor shall use a skills

performance checklist for this competency evaluation that includes, at least, all those skills specified in Rules .0501(h) and .0501(j) of this Section for the 25-hour training and all those skills specified in Rules .0501(h), (i) and (j) of this Section for the 80-hour training. Satisfactory performance of the personal care skills and interpersonal and behavioral intervention skills means that the trainee performed the skill unassisted; explained the procedure to the resident; explained to the instructor, prior to or after the procedure, what was being done and why it was being done in that way; and incorporated the principles of good body mechanics, medical asepsis and resident safety and privacy.

- (10) The training provider shall issue to all trainees who successfully complete the training a certificate, signed by the registered nurse who conducted the skills competency evaluation, stating that the trainee successfully completed the 25 or 80-hour training. The trainee's name shall be on the certificate. The training provider shall maintain copies of the certificates and the skills evaluation checklists for a minimum of five years.

(d) An individual, agency or organization seeking to provide the 25 or 80-hour training specified in Rule .0501 of this Section shall submit the following information to the Adult Care Licensure Section of the Division of Health Service Regulation:

- (1) an application which is available at no charge by contacting the Division of Health Service Regulation, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, North Carolina 27699-2708;
- (2) a statement of training program philosophy;
- (3) a statement of training program objectives for each content area;
- (4) a curriculum outline with specific hours for each content area;
- (5) teaching methodologies, a list of texts or other instructional materials and a copy of the written exam or testing instrument with an established passing grade;
- (6) a list of equipment and supplies to be used in the training;
- (7) procedures or steps to be completed in the performance of the personal care and basic nursing skills;
- (8) sites for classroom and supervised practical experience, including the specific settings or rooms within each site;
- (9) resumes of all instructors and the program coordinator, including current RN certificate numbers as applicable;
- (10) policy statements that address the role of the registered nurse, instructor to trainee ratio for the supervised practical experience, retention of trainee records and attendance requirements;
- (11) a skills performance checklist as specified in Subparagraph (c)(9) of this Rule; and
- (12) a certificate of successful completion of the training program.

(e) The following requirements shall apply to the competency evaluation for purposes of exempting adult care home staff from the 25 or 80-hour training as required in Rule .0501 of this Section:

- (1) The competency evaluation for purposes of exempting adult care home staff from the 25 and 80-hour training shall consist of the satisfactory performance of personal care skills and interpersonal and behavioral intervention skills according to the requirement in Subparagraph (c)(9) of this Rule.
- (2) Any person who conducts the competency evaluation for exemption from the 25 or 80-hour training shall be a registered nurse with the same qualifications specified in Subparagraph (c)(1) of this Rule.
- (3) The competency evaluation shall be conducted in a licensed adult care home or in a facility or laboratory setting comparable to the work setting in which the participant will be performing or supervising the personal care skills.
- (4) All skills being evaluated shall be performed on humans except for intimate care skills such as perineal and catheter care, which may be performed on a mannequin.
- (5) The person being competency evaluated in the setting of the person's employment shall not be considered on duty and counted in the staff-to-resident ratio.
- (6) An individual, agency or organization seeking to provide the competency evaluation for training exemption purposes shall complete an application available at no charge from the Division of Health Service Regulation, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, North Carolina 27699-2708 and submit it to the Adult Care Licensure Section along with the following information:
 - (A) resume of the person performing the competency evaluation, including the current RN certificate number;
 - (B) a certificate, with the signature of the evaluating registered nurse and the participant's name, to be issued to the person successfully completing the competency evaluation;

- (C) procedures or steps to be completed in the performance of the personal care and basic nursing skills;
- (D) a skills performance checklist as specified in Subparagraph (c)(9) of this Rule; a site for the competency evaluation; and a list of equipment, materials and supplies;
- (E) a site for the competency evaluation; and
- (F) a list of equipment, materials and supplies.

*History Note: Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 143B-165;
 Temporary Adoption Eff. January 1, 1996;
 Eff. May 1, 1997;
 Temporary Amendment Eff. December 1, 1999;
 Amended Eff. July 1, 2000.*

10A NCAC 13G .0503 MEDICATION ADMINISTRATION COMPETENCY EVALUATION

- (a) The competency evaluation for medication administration shall consist of a written examination and a clinical skills evaluation to determine competency in the following areas: medical abbreviations and terminology; transcription of medication orders; obtaining and documenting vital signs; procedures and tasks involved with the preparation and administration of oral (including liquid, sublingual and inhaler), topical (including transdermal), ophthalmic, otic, and nasal medications; infection control procedures; documentation of medication administration; monitoring for reactions to medications and procedures to follow when there appears to be a change in the resident's condition or health status based on those reactions; medication storage and disposition; regulations pertaining to medication administration in adult care facilities; and the facility's medication administration policy and procedures.
- (b) An individual shall score at least 90% on the written examination which shall be a standardized examination established by the Department.
- (c) A certificate of successful completion of the written examination shall be issued to each participant successfully completing the examination. A copy of the certificate shall be maintained and available for review in the facility. The certificate is transferable from one facility to another as proof of successful completion of the written examination. A medication study guide for the written examination is available at no charge by contacting the Division of Health Service Regulation, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708.
- (d) The clinical skills validation portion of the competency evaluation shall be conducted by a registered nurse or a registered pharmacist consistent with their occupational licensing laws and who has a current unencumbered license in North Carolina. This validation shall be completed for those medication administration tasks to be performed in the facility. Competency validation by a registered nurse is required for unlicensed staff who perform any of the personal care tasks related to medication administration specified in Rule .0903 of this Subchapter.
- (e) The Medication Administration Skills Validation Form shall be used to document successful completion of the clinical skills validation portion of the competency evaluation for those medication administration tasks to be performed in the facility employing the medication aide. Copies of this form and instructions for its use may be obtained at no cost by contacting the Adult Care Licensure Section, Division of Health Service Regulation, 2708 Mail Service Center, Raleigh, NC 27699-2708. The completed form shall be maintained and available for review in the facility and is not transferable from one facility to another.

*History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
 Temporary Adoption Eff. January 1, 2000; December 1, 1999;
 Eff. July 1, 2000.*

10A NCAC 13G .0504 COMPETENCY VALIDATION FOR LICENSED HEALTH PROFESSIONAL SUPPORT TASKS

- (a) A family care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision.
- (b) Competency validation shall be performed by the following licensed health professionals:
 - (1) A registered nurse shall validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(1) through (28) of Rule .0903 of this Subchapter.

- (2) In lieu of a registered nurse, a respiratory care practitioner licensed under G.S. 90, Article 38, may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(6), (11), (16), (18), (19) and (21) of Rule .0903 of this Subchapter.
- (3) In lieu of a registered nurse, a registered pharmacist may validate the competency of staff who perform the personal care task specified in Subparagraph (a)(8) of Rule .0903 of this Subchapter
- (4) In lieu of a registered nurse, an occupational therapist or physical therapist may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(17) and (a)(22) through (27) of Rule .0903 of this Subchapter.

(c) Competency validation of staff, according to Paragraph (a) of this Rule, for the licensed health professional support tasks specified in Paragraph (a) of Rule .0903 of this Subchapter and the performance of these tasks is limited exclusively to these tasks except in those cases in which a physician acting under the authority of G.S. 131D-2(a1) certifies that non-licensed personnel can be competency validated to perform other tasks on a temporary basis to meet the resident's needs and prevent unnecessary relocation.

*History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. September 1, 2003;
Eff. July 1, 2004.*

10A NCAC 13G .0505 TRAINING ON CARE OF DIABETIC RESIDENTS

A family care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows:

- (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner.
- (2) Training shall include at least the following:
 - (a) basic facts about diabetes and care involved in the management of diabetes;
 - (b) insulin action;
 - (c) insulin storage;
 - (d) mixing, measuring and injection techniques for insulin administration;
 - (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms;
 - (f) blood glucose monitoring; universal precautions; appropriate administration times; and
 - (g) sliding scale insulin administration.

*History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. September 1, 2003;
Eff. June 1, 2004.*

10A NCAC 13G .0506 TRAINING ON PHYSICAL RESTRAINTS

(a) A family care home shall assure that all staff responsible for caring for residents with medical symptoms that warrant restraints are trained on the use of alternatives to physical restraint use and on the care of residents who are physically restrained.

- (b) Training shall be provided by a registered nurse and shall include the following:
 - (1) alternatives to physical restraints;
 - (2) types of physical restraints;
 - (3) medical symptoms that warrant physical restraint;
 - (4) negative outcomes from using physical restraints;
 - (5) correct application of physical restraints;
 - (6) monitoring and caring for residents who are restrained; and
 - (7) the process of reducing restraint time by using alternatives.

*History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. September 1, 2003;
Eff. June 1, 2004.*

10A NCAC 13G .0507 TRAINING ON CARDIO-PULMONARY RESUSCITATION

Each family care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute and Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. If the only staff person on site has been deemed physically incapable of performing these procedures by a licensed physician, that person is exempt from the training.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. September 1, 2003;
Eff. July 1, 2004.

10A NCAC 13G .0508 ASSESSMENT TRAINING

The person or persons designated by the administrator to perform resident assessments as required by Rule .0801 of this Subchapter shall successfully complete training on resident assessment established by the Department before performing the required assessments. Registered nurses are exempt from the assessment training. The instruction manual on resident assessment is available on the internet website, <http://facility-services.state.nc.us/gcpage.htm>, or it is available at the cost of printing and mailing from the Division of Health Service Regulation, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. September 1, 2003;
Eff. June 1, 2004.

10A NCAC 13G .0509 FOOD SERVICE ORIENTATION

The family care home staff person in charge of the preparation and serving of food shall complete a food service orientation program established by the Department or an equivalent within 30 days of hire for those staff hired on or after July 1, 2004. The orientation program is available on the internet website, <http://facility-services.state.nc.us/gcpage.htm>, or it is available at the cost of printing and mailing from the Division of Health Service Regulation, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, 2005.

10A NCAC 13G .0510 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13G .0511 RESERVED FOR FUTURE CODIFICATION

10A NCAC 13G .0512 DOCUMENTATION OF TRAINING AND COMPETENCY VALIDATION

A family care home shall maintain documentation of the training and competency validation of staff required by the rules of this Section in the facility and available for review.

History Note: Authority G.S. 131D-2.16; 143B-165;
Temporary Amendment Eff. September 1, 2003;
Eff. June 1, 2004.

SECTION .0600 – STAFFING OF THE HOME

10A NCAC 13G .0601 MANAGEMENT AND OTHER STAFF

(a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.

(b) At all times there shall be one administrator or supervisor-in-charge who is directly responsible for assuring that all required duties are carried out in the home and for assuring that at no time is a resident left alone in the home without a staff member. Except for the provisions cited in Paragraph (c) of this Rule regarding the occasional absence of the administrator or supervisor-in-charge, one of the following arrangements shall be used:

- (1) The administrator shall be in the home or reside within 500 feet of the home with a means of two-way telecommunication with the home at all times. When the administrator does not live in the licensed home, there shall be at least one staff member who lives in the home or one on each shift and the administrator shall be directly responsible for assuring that all required duties are carried out in the home;
- (2) The administrator shall employ a supervisor-in-charge to live in the home or reside within 500 feet of the home with a means of two-way telecommunication with the home at all times. When the supervisor-in-charge does not live in the licensed home, there shall be at least one staff member who lives in the home or one on each shift and the supervisor-in-charge shall be directly responsible for assuring that all required duties are carried out in the home; or
- (3) When there is a cluster of licensed homes located adjacently on the same site, there shall be at least one staff member in each home, either live-in or on a shift basis, and at least one administrator or supervisor-in-charge who lives within 500 feet of each home with a means of two-way telecommunication with each home at all times and who is directly responsible for assuring that all required duties are carried out in each home.

(c) When the administrator or supervisor-in-charge is absent from the home or not within 500 feet of the home, the following shall apply:

- (1) For absences of a non-routine nature that do not exceed 24 hours per week, a relief-person-in-charge designated by the administrator shall be in charge of the home during the absence and in the home or within 500 feet of the home according to the requirements in Paragraph (b) of this Rule. The administrator shall assure that the relief-person-in-charge is prepared to respond appropriately in case of an emergency in the home. The relief-person-in-charge shall be 18 years or older.
- (2) For recurring or planned absences, a relief-supervisor-in-charge designated by the administrator shall be in charge of the home during the absence and in the home or within 500 feet of the home according to the requirements in Paragraph (b) of this Rule. The relief-supervisor-in-charge shall meet all of the qualifications required for the supervisor-in-charge as specified in Rule .0402 of this Subchapter with the exception of Item (4) pertaining to the continuing education requirement.

(d) Additional staff shall be employed as needed for housekeeping and the supervision and care of the residents.

(e) Information on required staffing shall be posted in the facility according to G.S. 131D-4.3(a)(5).

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; July 1, 1990; April 1, 1987; April 1, 1984; June 26, 1980.

10A NCAC 13G .0602 THE CO-ADMINISTRATOR

(a) The co-administrator shares the responsibilities with the administrator for the total operation of the home and for complying with the rules of this Subchapter.

(b) It shall be the shared responsibility of the co-administrators to notify the county department of social services in writing whenever any one of the co-administrators is unable or unwilling to continue managing the total operation of the home and must therefore be removed from the license. The county department will submit the written notice to the Division of Health Service Regulation.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984.

SECTION .0700 - ADMISSION AND DISCHARGE

10A NCAC 13G .0701 ADMISSION OF RESIDENTS

(a) Any adult (18 years of age or over) who, because of a temporary or chronic physical condition or mental disability, needs a substitute home may be admitted when, in the opinion of the resident, physician, family or social worker, and the administrator the services and accommodations of the home will meet his particular needs.

(b) Exceptions. People are not to be admitted:

- (1) for treatment of mental illness, or alcohol or drug abuse;
- (2) for maternity care;
- (3) for professional nursing care under continuous medical supervision;
- (4) for lodging, when the personal assistance and supervision offered for the aged and disabled are not needed; or
- (5) who pose a direct threat to the health or safety of others.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; January 1, 1989;
Temporary amendment Eff. October 14, 1992 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Amended Eff. February 1, 1993; April 1, 1992.*

10A NCAC 13G .0702 TUBERCULOSIS TEST AND MEDICAL EXAMINATION

(a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.

(b) Each resident shall have a medical examination prior to admission to the home and annually thereafter.

(c) The results of the complete examination are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following:

- (1) The examining date recorded on the FL-2 or MR-2 shall be no more than 90 days prior to the person's admission to the home.
- (2) The FL-2 or MR-2 shall be in the facility before admission or accompany the resident upon admission and be reviewed by the administrator or supervisor-in-charge before admission except for emergency admissions.
- (3) In the case of an emergency admission, the medical examination and completion of the FL-2 or MR-2 shall be within 72 hours of admission as long as current medication and treatment orders are available upon admission or there has been an emergency medical evaluation, including any orders for medications and treatments, upon admission.
- (4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the administrator or supervisor-in-charge shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs.
- (5) The completed FL-2 or MR-2 shall be filed in the resident's record in the home.
- (6) If a resident has been hospitalized, the facility shall have a completed FL-2 or MR-2 or a transfer form or discharge summary with signed prescribing practitioner orders upon the resident's return to the facility from the hospital.

(d) Each resident shall be immunized against pneumococcal disease and annually against influenza virus according to G.S. 131D-9, except as otherwise indicated in this law.

(e) The home shall make arrangements for any resident, who has been an inpatient of a psychiatric facility within 12 months before entering the home and who does not have a current plan for psychiatric care, to be examined by a local physician or a physician in a mental health center within 30 days after admission and to have a plan for psychiatric follow-up care when indicated.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. December 1, 1993; July 1, 1990; April 1, 1987; April 1, 1984;*

*Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004.*

10A NCAC 13G .0703 RESIDENT REGISTER

(a) A family care home's administrator or supervisor-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register within 72 hours of the resident's admission to the home. The Resident Register is available on the internet website, <http://facility-services.state.nc.us/gcpage.htm>, or at no charge from the Division of Health Service Regulation, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. The facility may use a resident information form other than the Resident Register as long as it contains at least the same information as the Resident Register.

(b) The administrator or supervisor-in-charge shall revise the completed Resident Register with the resident or his responsible person as needed.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1987; April 1, 1984;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005.*

10A NCAC 13G .0704 RESIDENT CONTRACT AND INFORMATION ON HOME

The administrator or supervisor-in-charge shall furnish and review with the resident or his responsible person information on the family care home upon admission and when changes are made to that information. A statement indicating that this information has been received upon admission or amendment as required by this Rule shall be signed and dated by each person to whom it is given. This statement shall be retained in the resident's record in the home. The information shall include:

- (1) a copy of the home's resident contract specifying rates for resident services and accommodations, including the cost of different levels of service, if applicable, any other charges or fees, and any health needs or conditions the home has determined it cannot meet pursuant to G.S. 131D-2(a1)(4). In addition, the following applies:
 - (a) The contract shall be signed and dated by the administrator or supervisor-in-charge and the resident or his responsible person and a copy given to the resident or his responsible person;
 - (b) The resident or his responsible person shall be notified as soon as any change is known, but not less than 30 days for rate changes initiated by the home, of any rate changes or other changes in the contract affecting the resident services and accommodations and be provided an amended copy of the contract for review and signature;
 - (c) A copy of each signed contract shall be kept in the resident's record in the home;
 - (d) Gratuities in addition to the established rates shall not be accepted; and
 - (e) The maximum monthly rate that may be charged to Special Assistance recipients is established by the North Carolina Social Services Commission and the North Carolina General Assembly;
Note: Facilities may accept payments for room and board from a third party, such as family member, charity or faith community, if the payment is made voluntarily to supplement the cost of room and board for the added benefit of a private room.
- (2) a written copy of any house rules, including the conditions for the discharge and transfer of residents, the refund policies, and the home's policies on smoking, alcohol consumption and visitation consistent with the rules in this Subchapter and amendments disclosing any changes in the house rules;
- (3) a copy of the Declaration of Residents' Rights as found in G.S. 131D-21;
- (4) a copy of the home's grievance procedures which shall indicate how the resident is to present complaints and make suggestions as to the home's policies and services on behalf of self or others; and
- (5) a statement as to whether the home has signed Form DSS-1464, Statement of Assurance of Compliance with Title VI of the Civil Rights Act of 1964 for Other Agencies, Institutions, Organizations or Facilities, and which shall also indicate that if the home does not choose to comply or is found to be in non-compliance the residents of the home would not be able to receive State-County

Special Assistance for Adults and the home would not receive supportive services from the county department of social services.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. April 1, 1984;
Amended Eff; July 1, 1990; April 1, 1987;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005.*

10A NCAC 13G .0705 DISCHARGE OF RESIDENTS

(a) The discharge of a resident initiated by the facility shall be according to conditions and procedures specified in Paragraphs (a) through (g) of this Rule. The discharge of a resident initiated by the facility involves the termination of residency by the facility resulting in the resident's move to another location and the facility not holding the bed for the resident based on the facility's bed hold policy.

(b) The discharge of a resident shall be based on one of the following reasons:

- (1) the discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility as documented by the resident's physician, physician assistant or nurse practitioner;
- (2) the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility as documented by the resident's physician, physician assistant or nurse practitioner;
- (3) the safety of other individuals in the facility is endangered;
- (4) the health of other individuals in the facility is endangered as documented by a physician, physician assistant or nurse practitioner;
- (5) failure to pay the costs of services and accommodations by the payment due date according to the resident contract after receiving written notice of warning of discharge for failure to pay; or
- (6) the discharge is mandated under G.S. 131D-2(a1).

(c) The notices of discharge and appeal rights as required in Paragraph (e) of this Rule shall be made by the facility at least 30 days before the resident is discharged except that notices may be made as soon as practicable when:

- (1) the resident's health or safety is endangered and the resident's urgent medical needs cannot be met in the facility under Subparagraph (b)(1) of this Rule; or
- (2) reasons under Subparagraphs (b)(2), (b)(3), and (b)(4) of this Rule exist.

(d) The reason for discharge shall be documented in the resident's record. Documentation shall include one or more of the following as applicable to the reasons under Paragraph (b) of this Rule:

- (1) documentation by physician, physician assistant or nurse practitioner as required in Paragraph (b) of this Rule;
- (2) the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility's action taken to address the problem prior to pursuing discharge of the resident;
- (3) written notices of warning of discharge for failure to pay the costs of services and accommodations; or
- (4) the specific health need or condition of the resident that the facility determined could not be met in the facility pursuant to G.S. 131D-2(a1)(4) and as disclosed in the resident contract signed upon the resident's admission to the facility.

(e) The facility shall assure the following requirements for written notice are met before discharging a resident:

- (1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from the Division of Medical Assistance, 2505 Mail Service Center, Raleigh, NC 27699-2505.
- (2) A copy of the Adult Care Home Notice of Discharge with a copy of the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative on the same day the Adult Care Home Notice of Discharge is dated.
- (3) Failure to use and simultaneously provide the specific forms according to Subparagraphs (e)(1) and (e)(2) of this Rule shall invalidate the discharge. Failure to use the latest version of these forms shall not invalidate the discharge unless the facility has been previously notified of a change in the forms and been provided a copy of the latest forms by the Department of Health and Human Services.

- (4) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record.
- (f) The facility shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by:
- (1) notifying staff in the county department of social services responsible for placement services;
 - (2) explaining to the resident and responsible person or legal representative why the discharge is necessary;
 - (3) informing the resident and responsible person or legal representative about an appropriate discharge destination; and
 - (4) offering the following material to the caregiver with whom the resident is to be placed and providing this material as requested prior to or upon discharge of the resident:
 - (A) a copy of the resident's most current FL-2;
 - (B) a copy of the resident's most current assessment and care plan;
 - (C) a copy of the resident's current physician orders;
 - (D) a list of the resident's current medications;
 - (E) the resident's current medications; and
 - (F) a record of the resident's vaccinations and TB screening.
 - (5) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (e) of this Rule:
 - (A) the regional long term care ombudsman; and
 - (B) the protection and advocacy agency established under federal law for persons with disabilities.
- (g) If an appeal hearing is requested:
- (1) the facility shall provide to the resident or legal representative or the resident and the responsible person, and the Hearing Unit copies of all documents and records that the facility intends to use at the hearing at least five working days prior to the scheduled hearing; and
 - (2) the facility shall not discharge the resident before the final decision resulting from the appeal has been rendered, except in those cases of discharge specified in Paragraph (c) of this Rule.
- (h) If a discharge is initiated by the resident or responsible person, the administrator may require up to a 14-day written notice from the resident or responsible person which means the resident or responsible person may be charged for the days of the required notice if notice is not given or if notice is given and the resident leaves before the end of the required notice period. Exceptions to the required notice are cases in which a delay in discharge or transfer would jeopardize the health or safety of the resident or others in the facility. The facility's requirement for a notice from the resident or responsible person shall be established in the resident contract or the house rules provided to the resident or responsible person upon admission.
- (i) The discharge requirements in this Rule do not apply when a resident is transferred to an acute inpatient facility for mental or physical health evaluation or treatment and the adult care facility's bed hold policy applies based on the expected return of the resident. If the facility decides to discharge a resident who has been transferred to an acute inpatient facility and there has been no physician-documented level of care change for the resident, the discharge requirements in this Rule apply.

History Note: Authority G.S. 131D-2.1; 131D-2.16; 131D-4.8; 131D-4.5; 131D-21; 143B-165; Temporary Adoption Eff. January 1, 2000; December 1, 1999; Eff. April 1, 2001; Temporary Amendment Eff. July 1, 2003; Amended Eff. July 1, 2004.

SECTION .0800 - RESIDENT ASSESSMENT AND CARE PLAN

10A NCAC 13G .0801 RESIDENT ASSESSMENT

- (a) A family care home shall assure that an initial assessment of each resident is completed within 72 hours of admission using the Resident Register.
- (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the

Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource.

(c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows:

- (1) Significant change is one or more of the following:
 - (A) deterioration in two or more activities of daily living;
 - (B) change in ability to walk or transfer;
 - (C) change in the ability to use one's hands to grasp small objects;
 - (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic;
 - (E) no response by the resident to the treatment for an identified problem;
 - (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period;
 - (G) threat to life such as stroke, heart condition, or metastatic cancer;
 - (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher;
 - (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being over a period of time such as initial diagnosis of Alzheimer's disease or diabetes;
 - (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed;
 - (K) new onset of impaired decision-making;
 - (L) continence to incontinence or indwelling catheter; or
 - (M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident.
- (2) Significant change is not any of the following:
 - (A) changes that suggest slight upward or downward movement in the resident's status;
 - (B) changes that resolve with or without intervention;
 - (C) changes that arise from easily reversible causes;
 - (D) an acute illness or episodic event;
 - (E) an established, predictive, cyclical pattern; or
 - (F) steady improvement under the current course of care.

(d) If a resident experiences a significant change as defined in Paragraph (c) of this Rule, the facility shall refer the resident to the resident's physician or other appropriate licensed health professional such as a mental health professional, nurse practitioner, physician assistant or registered nurse in a timely manner consistent with the resident's condition but no longer than 10 days from the significant change, and document the referral in the resident's record. Referral shall be made immediately when significant changes are identified that pose an immediate risk to the health and safety of the resident, other residents or staff of the facility.

(e) The assessments required in Paragraphs (b) and (c) of this Rule shall be completed and signed by the person designated by the administrator to perform resident assessments.

*History Note: Authority G.S. 131D-2.16; 131D-4.4; 131D-4.5; 143B-165;
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. July 1, 2005; June 1, 2004.*

- (a) A family care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan shall be an individualized, written program of personal care for each resident.
- (b) The care plan shall be revised as needed based on further assessments of the resident according to Rule .0801 of this Subchapter.
- (c) The care plan shall include the following:
 - (1) a statement of the care or service to be provided based on the assessment or reassessment; and
 - (2) frequency of the service provision.
- (d) The assessor shall sign the care plan upon its completion.
- (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment:
 - (1) the resident is under the physician's care; and
 - (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan.
- (f) The facility shall assure that the care plan for each resident who is under the care of a provider of mental health, developmental disabilities or substance abuse services includes resident specific instructions regarding how to contact that provider, including emergency contact. Whenever significant behavioral changes described in Rule .0801(c)(1)(D) of this Subchapter are identified, the facility shall refer the resident to a provider of mental health, developmental disabilities or substance abuse services in accordance with Rule .0801(d) of this Subchapter.

History Note: Authority G.S. 131D-2.16; 131D-4.3; 131D-4.4; 131D-4.5; 143B-165; Temporary Adoption Eff. January 1, 1996; Eff. May 1, 1997; Temporary Amendment Eff. January 1, 2001; Temporary Amendment Expired October 13, 2001; Temporary Amendment Eff. September 1, 2003; Amended Eff. July 1, 2005; June 1, 2004.

SECTION .0900 – RESIDENT CARE AND SERVICES

10A NCAC 13G .0901 PERSONAL CARE AND SUPERVISION

- (a) Family care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.
- (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.
- (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.

History Note: Authority G.S. 131D-2.16; 131D-4.3; 143B-165; Eff. January 1, 1977; Readopted Eff. October 31, 1977; Amended Eff. July 1, 2005; May 1, 1999; July 1, 1990; April 1, 1987; April 1, 1984.

10A NCAC 13G .0902 HEALTH CARE

- (a) A family care home shall provide care and services in accordance with the resident's care plan.
- (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.
- (c) The facility shall assure documentation of the following in the resident's record:
 - (1) facility contacts with the resident's physician, physician service, other licensed health professional, including mental health professional, when illnesses or accidents occur and any other facility contacts with a physician or licensed health professional regarding resident care;
 - (2) all visits of the resident to or from the resident's physician, physician service or other licensed health professional, including mental health professional, of which the facility is aware.
 - (3) written procedures, treatments or orders from a physician or other licensed health professional; and
 - (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.
- (d) The following shall apply to the resident's physician or physician service:

- (1) The resident or the resident's responsible person shall be allowed to choose a physician or physician service to attend the resident.
- (2) When the resident cannot remain under the care of the chosen physician or physician service, the facility shall assure that arrangements are made with the resident or responsible person for choosing and securing another physician or physician service within 45 days or prior to the signing of the care plan as required in Rule .0802 of this Subchapter.

History Note: Authority G.S. 131D-2.16; 131D-4.3; 143B-165; Eff. January 1, 1977; Readopted Eff. October 31, 1977; Amended Eff. December 1, 1993; May 1, 1992, July 1, 1990; September 1, 1987; Temporary Amendment Eff. December 1, 1999; Amended Eff. July 1, 2000; Temporary Amendment Eff. September 1, 2003; Amended Eff. July 1, 2005; June 1, 2004.

10A NCAC 13G .0903 LICENSED HEALTH PROFESSIONAL SUPPORT

(a) A family care home shall assure that an appropriate licensed health professional, participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks:

- (1) applying and removing ace bandages, ted hose, binders, and braces and splints;
- (2) feeding techniques for residents with swallowing problems;
- (3) bowel or bladder training programs to regain continence;
- (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches;
- (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter;
- (6) chest physiotherapy or postural drainage;
- (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents;
- (8) collecting and testing of fingerstick blood samples;
- (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage);
- (10) care for pressure ulcers, up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater;
- (11) inhalation medication by machine;
- (12) forcing and restricting fluids;
- (13) maintaining accurate intake and output data;
- (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established);
- (15) medication administration through injection;
Note: Unlicensed staff may only administer subcutaneous injections as stated in Rule .1004(q) of this Subchapter;
- (16) oxygen administration and monitoring;
- (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints;
- (18) oral suctioning;
- (19) care of well-established tracheostomy, not to include indo-tracheal suctioning;
- (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph (14) of this Paragraph);
- (21) the monitoring of continuous positive air pressure devices (CPAP and BIPAP);
- (22) application of prescribed heat therapy;
- (23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity;
- (24) ambulation using assistive devices that requires physical assistance;
- (25) range of motion exercises;

- (26) any other prescribed physical or occupational therapy;
 - (27) transferring semi-ambulatory or non-ambulatory residents; or
 - (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36.
- (b) The appropriate licensed health professional, as required in Paragraph (a) of this Rule, is:
- (1) a registered nurse licensed under G.S. 90, Article 9A, for tasks listed in Subparagraphs (a)(1) through (28) of this Rule;
 - (2) an occupational therapist licensed under G.S. 90, Article 18D or physical therapist licensed under G.S. 90-270.24, Article 18B for tasks listed in Subparagraphs (a)(17) and (a)(22) through (27) of this Rule;
 - (3) a respiratory care practitioner licensed under G.S. 90, Article 38, for tasks listed in Subparagraphs (a)(6), (11), (16), (18), (19) and (21) of this Rule; or
 - (4) a registered nurse licensed under G.S. 90, Article 9A, for tasks that can be performed by a nurse aide II according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36.
- (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following:
- (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;
 - (2) evaluating the resident's progress to care being provided;
 - (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and
 - (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.
- (d) The facility shall assure action is taken in response to the licensed health professional review and documented, and that the physician or appropriate health professional is informed of the recommendations when necessary.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165; Temporary Adoption Eff. January 1, 1996; Eff. May 1, 1997; Temporary Amendment Eff. December 1, 1999; Amended Eff. July 1, 2000; Temporary Amendment Eff. September 1, 2003; Amended Eff. June 1, 2004.

10A NCAC 13G .0904 NUTRITION AND FOOD SERVICE

- (a) Food Procurement and Safety in Family Care Homes:
- (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.
 - (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination.
 - (3) All meat processing shall occur at a USDA-approved processing plant.
 - (4) There shall be at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets.
- (b) Food Preparation and Service in Family Care Homes:
- (1) Sufficient staff, space and equipment shall be provided for safe and sanitary food storage, preparation and service.
 - (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident.
 - (3) Hot foods shall be served hot and cold foods shall be served cold.
 - (4) If residents require feeding assistance, food shall be maintained at serving temperature until assistance is provided.
- (c) Menus in Family Care Homes:
- (1) Menus shall be prepared at least one week in advance with serving quantities specified and in accordance with the Daily Food Requirements in Paragraph (d) of this Rule.

- (2) Menus shall be maintained in the kitchen and identified as to the current menu day and cycle for any given day for guidance of food service staff.
- (3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents.
- (4) Menus shall be planned to take into account the food preferences and customs of the residents.
- (5) Menus as served and invoices or other receipts of purchases shall be maintained in the facility for 30 days.
- (6) Menus for all therapeutic diets shall be planned or reviewed by a registered dietitian. The facility shall maintain verification of the registered dietitian's approval of the therapeutic diets which shall include an original signature by the registered dietitian and the registration number of the dietitian.
- (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff.

(d) Food Requirements in Family Care Homes:

- (1) Each resident shall be served a minimum of three nutritionally adequate, palatable meals a day at regular hours with at least 10 hours between the breakfast and evening meals.
- (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.
- (3) Daily menus for regular diets shall include the following:
 - (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used.
 - (B) Fruit: Two servings of fruit (one serving equals 6 ounces of juice; ½ cup of raw, canned or cooked fruit; 1 medium-size whole fruit; or ¼ cup dried fruit). One serving shall be a citrus fruit or a single strength juice in which there is 100% of the recommended dietary allowance of vitamin C in each six ounces of juice. The second fruit serving shall be of another variety of fresh, dried or canned fruit.
 - (C) Vegetables: Three servings of vegetables (one serving equals ½ cup of cooked or canned vegetable; 6 ounces of vegetable juice; or 1 cup of raw vegetable). One of these shall be a dark green, leafy or deep yellow three times a week.
 - (D) Eggs: One whole egg or substitute (e.g., 2 egg whites or ¼ cup of pasteurized egg product) at least three times a week at breakfast.
 - (E) Protein: Two to three ounces of pure cooked meat at least two times a day for a minimum of 4 ounces. A substitute (e.g., 4 tablespoons of peanut butter, 1 cup of cooked dried peas or beans or 2 ounces of pure cheese) may be served three times a week but not more than once a day, unless requested by the resident.
Note: Bacon is considered to be fat and not meat for the purposes of this Rule.
 - (F) Cereals and Breads: At least six servings of whole grain or enriched cereal and bread or grain products a day. Examples of one serving are as follows: 1 slice of bread; ½ of a bagel, English muffin or hamburger bun; one 1 ½ -ounce muffin, 1- ounce roll, 2-ounce biscuit or 2-ounce piece of cornbread; ½ cup cooked rice or cereal (e.g., oatmeal or grits); ¾ cup ready-to-eat cereal; or one waffle, pancake or tortilla that is six inches in diameter. Cereals and breads offered as snacks may be included in meeting this requirement.
 - (G) Fats: Include butter, oil, margarine or items consisting primarily of one of these (e.g., icing or gravy).
 - (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages.

(e) Therapeutic Diets in Family Care Homes:

- (1) All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician. Where applicable, the therapeutic diet order shall be specific to calorie, gram or consistency, such as for calorie controlled ADA diets, low sodium diets or thickened liquids, unless there are written orders which include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a registered dietitian.

- (2) Physician orders for nutritional supplements shall be in writing from the resident's physician and be brand specific, unless the facility has defined a house supplement in its communication to the physician, and shall specify quantity and frequency.
 - (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.
 - (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.
- (f) Individual Feeding Assistance in Family Care Homes:
- (1) Sufficient staff shall be available for individual feeding assistance as needed.
 - (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.
- (g) Variations from the required three meals or time intervals between meals to meet individualized needs or preferences of residents shall be documented in the resident's record.

*History Note: Authority G.S. 131D-2.16; 143B-165;
 Eff. January 1, 1977;
 Amended Eff. October 1, 1977; April 22, 1977;
 Readopted Eff. October 31, 1977;
 Amended Eff. August 3, 1992; July 1, 1990; September 1, 1987; April 1, 1987;
 Temporary Amendment Eff. July 1, 2003;
 Amended Eff. June 1, 2004.*

10A NCAC 13G .0905 ACTIVITIES PROGRAM

- (a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community.
- (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities.
- (c) The activity director, as required in Rule .0404 of this Subchapter, shall:
 - (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities and possible cultural differences of the residents;
 - (2) prepare a monthly calendar of planned group activities which shall be easily readable with large print, posted in a prominent location by the first day of each month, and updated when there are any changes;
 - (3) involve community resources, such as recreational, volunteer, religious, aging and developmentally disabled-associated agencies, to enhance the activities available to residents;
 - (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program;
 - (5) encourage residents to participate in activities; and
 - (6) assure there are adequate supplies, supervision and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities.
- (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees.
- (e) Residents shall have the opportunity to participate in activities involving one to one interaction and activity by oneself that promote enjoyment, a sense of accomplishment, increased knowledge, learning of new skills, and creative expression. Examples of these activities are crafts, painting, reading, creative writing, buddy walks, card playing, and nature walks.
- (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so.

(g) Each resident shall have the opportunity to participate in meaningful work-type and volunteer service activities in the home or in the community, but participation shall be on an entirely voluntary basis, never forced upon residents and not assigned in place of staff.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. August 3, 1992; April 1, 1987; April 1, 1984;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005.*

10A NCAC 13G .0906 OTHER RESIDENT SERVICES

(a) Transportation. The administrator must assure the provision of transportation for the residents to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the resident's choice. The resident is not to be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members as well as facility vehicles.

(b) Mail.

- (1) Residents shall receive their mail promptly and it must be unopened unless there is a written, witnessed request authorizing management staff to open and read mail to the resident. This request must be recorded on Form DSS-1865, the Resident Register or the equivalent;
- (2) Outgoing mail written by a resident shall not be censored; and
- (3) Residents shall be encouraged and assisted, if necessary, to correspond by mail with close relatives and friends. Residents shall have access to writing materials, stationery and postage and, upon request, the home is to provide such items at cost. It is not the home's obligation to pay for these items.

(c) Laundry.

- (1) Laundry services must be provided to residents without any additional fee; and
- (2) It is not the home's obligation to pay for a resident's personal dry cleaning. The resident's plans for personal care of clothing are to be indicated on Form DSS-1865, the Resident Register.

(d) Telephone.

- (1) A telephone must be available in a location providing privacy for residents to make and receive a reasonable number of calls of a reasonable length;
- (2) A pay station telephone is not acceptable for local calls; and
- (3) It is not the home's obligation to pay for a resident's toll calls.

(e) Personal Lockable Space.

- (1) Personal lockable space must be provided for each resident to secure his personal valuables. One key shall be provided free of charge to the resident. Additional keys are to be provided to residents at cost upon request. It is not the home's obligation to pay for additional keys; and
- (2) While a resident may elect not to use lockable space, it must still be available in the home since the resident may change his mind. This space shall be accessible only to the resident and the administrator or supervisor-in-charge. The administrator or supervisor-in-charge must determine at admission whether the resident desires lockable space, but the resident may change his mind at any time.

(f) Visiting.

- (1) Visiting in the home and community at reasonable hours shall be encouraged and arranged through the mutual prior understanding of the residents and administrator;
- (2) There must be at least 10 hours each day for visitation in the home by persons from the community. If a home has established visiting hours or any restrictions on visitation, information about the hours and any restrictions must be included in the house rules given to each resident at the time of admission and posted conspicuously in the home;
- (3) A signout register must be maintained for planned visiting and other scheduled absences which indicates the resident's departure time, expected time of return and the name and telephone number of the responsible party;
- (4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home must immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. December 1, 1991; April 1, 1987; April 1, 1984.*

10A NCAC 13G .0907 RESPITE CARE

- (a) For the purposes of this Subchapter, respite care is defined as supervision, personal care and services provided for persons admitted to a family care home on a temporary basis for temporary caregiver relief, not to exceed 30 days.
- (b) Respite care is not required as a condition of licensure. However, respite care is subject to the requirements of this Subchapter except for Rules .0703, .0705, .0801, .0802 and .1201.
- (c) The number of respite care residents and family care home residents shall not exceed the facility's licensed bed capacity.
- (d) The respite care resident contract shall specify the rates for respite care services and accommodations, the date of admission to the facility and the proposed date of discharge from the facility. The contract shall be signed by the administrator or designee and the respite care resident or his responsible person and a copy given to the resident and responsible person.
- (e) Upon admission of a respite care resident into the facility, the facility shall assure that the resident has a current FL-2 and been tested for tuberculosis disease according to Rule .0702 of this Subchapter and that there are current physician orders for any medications, treatments and special diets for inclusion in the respite care resident's record. The facility shall assure that the respite care resident's physician or prescribing practitioner is contacted for verification of orders if the orders are not signed and dated within seven calendar days prior to admission to the facility as a respite care resident or for clarification of orders if orders are not clear or complete.
- (f) The facility shall complete an assessment which allows for the development of a short-term care plan prior to or upon admission to the facility with input from the resident or responsible person. The assessment shall address respite resident needs, including identifying information, hearing, vision, cognitive ability, functional limitations, continence, special procedures and treatments as ordered by physician, skin conditions, behavior and mood, oral and nutritional status and medication regimen. The facility may use the Resident Register or an equivalent as the assessment instrument. The care plan shall be signed and dated by the facility's administrator or designated representative and the respite care resident or responsible person.
- (g) The respite care resident's record shall include a copy of the signed respite care contract; the FL-2; the assessment and care plan; documentation of a tuberculosis test according to Paragraph (e) of this Rule; documentation of any contacts (office, home or telephone) with the resident's physician or other licensed health professionals from outside the facility; physician orders; medication administration records; a statement, signed and dated by the resident or responsible person, indicating that information on the home as required in Rule .0704 of this Subchapter has been received; a written description of any acute changes in the resident's condition or any incidents or accidents resulting in injury to the respite care resident, and any action taken by the facility in response to the changes, incidents or accidents; and how the responsible person or his designated representative can be contacted in case of an emergency.
- (h) The respite care resident's responsible person or his designated representative shall be contacted and informed of the need to remove the resident from the facility if one or more of the following conditions exists:
- (1) the resident's condition is such that he is a danger to himself or poses a direct threat to the health of others as documented by a physician; or
 - (2) the safety of individuals in the home is threatened by the behavior of the resident as documented by the facility.

Documentation of the emergency discharge shall be on file in the facility.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Temporary Adoption Eff. November 1, 2000;
Eff. July 18, 2002;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005.*

10A NCAC 13G .0908 COOPERATION WITH CASE MANAGERS

The administrator shall cooperate with and assure the cooperation of facility staff with case managers in their provision of case management services to the appropriate residents.

*History Note: Authority G.S. 131D-2.16; 131D-4.3; 143B-165;
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997.*

10A NCAC 13G .0909 RESIDENT RIGHTS

A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

*History Note: Authority G.S. 131D-2.16; 131D-21; 143B-165;
Temporary Adoption Eff. July 1, 2004;
Eff. July 1, 2005.*

SECTION .1000 – MEDICATIONS

10A NCAC 13G .1001 MEDICATION ADMINISTRATION POLICIES AND PROCEDURES

In addition to the requirements in Rule .1211(a)(1) of this Subchapter, a family care home shall ensure the following:

- (1) orientation to medication policies and procedures for staff responsible for medication administration prior to their administering or supervising the administration of medications; and
- (2) compliance of medication policies and procedures with requirements of this Section and all applicable state and federal regulations, including definitions in the North Carolina Pharmacy Practice Act, G.S. 90-85.3.

For the purposes of this Subchapter, medications include herbal and non-herbal supplements.

*History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Amended Eff. July 1, 2005.*

10A NCAC 13G .1002 MEDICATION ORDERS

(a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:

- (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;
- (2) if orders are not clear or complete; or
- (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.

The facility shall ensure that this verification or clarification is documented in the resident's record.

(b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility.

(c) The medication orders shall be complete and include the following:

- (1) medication name;
- (2) strength of medication;
- (3) dosage of medication to be administered;
- (4) route of administration;
- (5) specific directions of use, including frequency of administration; and
- (6) if ordered on an as needed basis, a stated indication for use.

(d) Verbal orders for medications and treatments shall be:

- (1) countersigned by the prescribing practitioner within 15 days from the date the order is given;
- (2) signed or initialed and dated by the person receiving the order; and
- (3) accepted only by a licensed professional authorized by state occupational licensure laws to accept orders or staff responsible for medication administration.

(e) Any standing orders shall be for individual residents and signed and dated by the resident's physician or prescribing practitioner.

(f) The facility shall assure that all current orders for medications or treatments, including standing orders and orders for self-administration, are reviewed and signed by the resident's physician or prescribing practitioner at least every six months.

(g) In addition to the requirements as stated in Paragraph (c) of this Rule, psychotropic medications ordered "as needed" by a prescribing practitioner, shall not be administered unless the following have been provided by the practitioner or included in an individualized care plan developed with input by a registered nurse or licensed pharmacist:

- (1) detailed behavior-specific written instructions, including symptoms that might require use of the medication;
- (2) exact dosage;
- (3) exact time frames between dosages; and
- (4) the maximum dosage to be administered in a twenty-four hour period.

(h) The facility shall assure that personal care aides and their direct supervisors receive training annually about the desired and undesired effects of psychotropic medications, including alternative behavior interventions. Documentation of training attended by staff shall be maintained in the facility.

*History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Amended Eff. July 1, 2005.*

10A NCAC 13G .1003 MEDICATION LABELS

(a) Labeling of prescription legend medications, except for medications prepared for a resident's leave of absence in accordance with Rule .1010(d)(4) of this Section, shall be legible and include the following information:

- (1) the name of the resident for whom the medication is prescribed;
- (2) the most recent date of issuance;
- (3) the name of the prescriber;
- (4) the name and concentration of the medication, quantity dispensed, and prescription serial number;
- (5) unabbreviated directions for use stated;
- (6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed;
- (7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date;
- (8) auxiliary information as required of the medication;
- (9) the name, address, and telephone number of the dispensing pharmacy; and
- (10) the name or initials of the dispensing pharmacist.

(b) For medication systems in which two or more prescribed solid oral dosage forms are packaged and dispensed together, labeling shall be in accordance with Paragraph (a) of this Rule and the label or package shall also have a physical description or identification of each medication contained in the package.

(c) The facility shall assure any changes in directions of a resident's medication by the prescriber are on the container at the refilling of the medication by the pharmacist or dispensing practitioner. The facility shall have a procedure for identifying direction changes until the container is correctly labeled in accordance with Paragraph (a) of this Rule. No person other than a licensed pharmacist or dispensing practitioner shall alter a prescription label.

(d) Non-prescription medications shall have the manufacturer's label with the expiration date visible, unless the container has been labeled by a licensed pharmacist or a dispensing practitioner in accordance with Paragraph (a) of this Rule. Non-prescription medications in the original manufacturer's container shall be labeled with at least the resident's name and the name shall not obstruct any of the information on the container. Facility staff may label or write the resident's name on the container.

(e) Medications, prescription and non-prescription, shall not be transferred from one container to another except when prepared for a resident's leave of absence or administration to a resident.

*History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Amended Eff. April 1, 2015.*

10A NCAC 13G .1004 MEDICATION ADMINISTRATION

(a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with:

- (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
- (2) rules in this Section and the facility's policies and procedures.

(b) The facility shall assure that only staff meeting the requirements in Rule .0403 of this Subchapter shall administer medications, including the preparation of medications for administration.

(c) Only oral solid medications that are ordered for routine administration may be prepared in advance and must be prepared within 24 hours of the prescribed time for administration. Medications prescribed for prn (as needed) administration shall not be prepared in advance.

(d) Liquid medications, including powders or granules that require to be mixed with liquids for administration, and medications for injection shall be prepared immediately before administration to a resident.

(e) Medications shall not be crushed for administration until immediately before the medications are administered to the resident.

(f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage:

- (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container;
- (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name;
- (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and
- (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section.

(g) The facility shall ensure that medications are administered within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations.

(h) If medications are not prepared and administered by the same staff person, there shall be documentation for each dose of medication prepared for administration by the staff person who prepared the medications when or at the time the resident's medication is prepared. Procedures shall be established and implemented to identify the staff person who prepared the medication and the staff person who administered the medication.

(i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

(j) The resident's medication administration record (MAR) shall be accurate and include the following:

- (1) resident's name;
- (2) name of the medication or treatment order;
- (3) strength and dosage or quantity of medication administered;
- (4) instructions for administering the medication or treatment;
- (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
- (6) date and time of administration;
- (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and
- (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

(k) The facility shall have a system in place to ensure the resident is identified prior to the administration of any medication or treatment.

- (l) The facility shall assure the development and implementation of policies and procedures governing medication errors and adverse medication reactions that include documentation of the following:
- (1) notification of a physician or appropriate health professional and supervisor;
 - (2) action taken by the facility according to orders by the physician or appropriate health professional; and
 - (3) charting or documentation errors, unavailability of a medication, resident refusal of medication, any adverse medication reactions and notification of the resident's physician when necessary.
- (m) Medication administration supplies, such as graduated measuring devices, shall be available and used by facility staff in order for medications to be accurately and safely administered.
- (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.
- (o) A resident's medication shall not be administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly and that the borrowing and replacement of the medication shall be documented.
- (p) Only oral, topical (including ophthalmic and otic medications), inhalants, rectal and vaginal medications, subcutaneous injections and medications administered by gastrostomy tube and nebulizers may be administered by persons who are not authorized by state occupational licensure laws to administer medication.
- (q) Unlicensed staff may not administer insulin or other subcutaneous injections prior to meeting the requirements for training and competency validation as stated in Rules .0504 and .0505 of this Subchapter.

*History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Amended Eff. July 1, 2005.*

10A NCAC 13G .1005 SELF-ADMINISTRATION OF MEDICATIONS

- (a) The facility shall permit residents who are competent and physically able to self-administer to self-administer their medications if the following requirements are met:
- (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and
 - (2) specific instructions for administration of prescription medications are printed on the medication label.
- (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications.

*History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000.*

10A NCAC 13G .1006 MEDICATION STORAGE

- (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the facility's medication storage policy and procedures.
- (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration.
- (c) The medication storage area shall be clean, well-lighted, well-ventilated, large enough to store medications in an orderly manner, and located in areas other than the bathroom, kitchen or utility room. Medication carts shall be clean and medications shall be stored in an orderly manner.
- (d) Accessibility to locked storage areas for medications shall only be by staff responsible for medication administration and administrator or person in charge.
- (e) Medications intended for topical or external use, except for ophthalmic, otic and transdermal medications, shall be stored in a designated area separate from the medications intended for oral and injectable use. Ophthalmic, otic and transdermal medications may be stored with medications intended for oral and injectable use. Medications shall be stored apart from cleaning agents and hazardous chemicals.
- (f) Medications requiring refrigeration shall be stored at 36 degrees F to 46 degrees F (2 degrees C to 8 degrees C).

(g) Medications shall not be stored in a refrigerator containing non-medications and non-medication related items, except when stored in a separate container. The container shall be locked when storing medications unless the refrigerator is locked or is located in a locked medication area.

(h) The facility shall only possess a stock of non-prescription medications or the following prescription legend medications for general or common use:

- (1) irrigation solutions in single unit quantities exceeding 49 ml. and related diagnostic agents;
- (2) diagnostic agents;
- (3) vaccines; and
- (4) water for injection and normal saline for injection.

Note: A prescribing practitioner's order is required for the administration of any medication as stated in Rule .1004 (a) of this Section.

(i) First aid supplies shall be immediately available, stored out of sight of residents and visitors and stored separately in a secure and orderly manner.

*History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000.*

10A NCAC 13G .1007 MEDICATION DISPOSITION

(a) Medications shall be released to or with a resident upon discharge if the resident has a physician's order to continue the medication. Prescribed medications are the property of the resident and shall not be given to, or taken by, other staff or residents according to Rule .1004(o) of this Subchapter.

(b) Medications, excluding controlled medications, that are expired, discontinued, prescribed for a deceased resident or deteriorated shall be stored separately from actively used medications until disposed of.

(c) Medications, excluding controlled medications, shall be destroyed at the facility or returned to a pharmacy within 90 days of the expiration or discontinuation of medication or following the death of the resident.

(d) All medications destroyed at the facility shall be destroyed by the administrator or the administrator's designee and witnessed by a pharmacist, a dispensing practitioner, or their designee. The destruction shall be conducted so that no person can use, administer, sell or give away the medication.

(e) Records of medications destroyed or returned to the pharmacy shall include the resident's name, the name and strength of the medication, the amount destroyed or returned, the method of destruction if destroyed in the facility and the signature of the administrator or the administrator's designee and the signature of the pharmacist, dispensing practitioner or their designee. These records shall be maintained by the facility for a minimum of one year.

(f) A dose of any medication prepared for administration and accidentally contaminated or not administered shall be destroyed at the facility according to the facility's policies and procedures.

*History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000.*

10A NCAC 13G .1008 CONTROLLED SUBSTANCES

(a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.

(b) Controlled substances may be stored together in a common location or container. If Schedule II medications are stored together in a common location, the Schedule II medications shall be under double lock.

(c) Controlled substances that are expired, discontinued or no longer required for a resident shall be returned to the pharmacy within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The facility shall document the resident's name; the name, strength and dosage form of the controlled substance; and the amount returned. There shall also be documentation by the pharmacy of the receipt or return of the controlled substances.

(d) If the pharmacy will not accept the return of a controlled substance, the administrator or the administrator's designee shall destroy the controlled substance within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The destruction shall be witnessed by a licensed pharmacist, dispensing practitioner, or designee of a licensed pharmacist or dispensing practitioner. The destruction shall be conducted so that no person can

use, administer, sell or give away the controlled substance. Records of controlled substances destroyed shall include the resident's name; the name, strength and dosage form of the controlled substance; the amount destroyed; the method of destruction; and, the signature of the administrator or the administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner.

(e) Records of controlled substances returned to the pharmacy or destroyed by the facility shall be maintained by the facility for a minimum of three years.

(f) Controlled substances that are expired, discontinued, prescribed for a deceased resident or deteriorated shall be stored securely in a locked area separately from actively used medications until disposed of.

(g) A dose of a controlled substance accidentally contaminated or not administered shall be destroyed at the facility. The destruction shall be documented on the medication administration record (MAR) or the controlled substance record showing the time, date, quantity, manner of destruction and the initials or signature of the person destroying the substance.

(h) The facility shall ensure that all known drug diversions are reported to the pharmacy, the local law enforcement agency and Health Care Personnel Registry as required by state law and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken.

*History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000;
Amended Eff. July 1, 2005.*

10A NCAC 13G .1009 PHARMACEUTICAL CARE

(a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following:

- (1) an on-site medication review for each resident which includes at least the following:
 - (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and,
 - (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and,
 - (C) documenting the results of the medication review in the resident's record;
- (2) review of all aspects of medication administration including the observation or review of procedures for the administration of medications and inspection of medication storage areas;
- (3) review of the medication system utilized by the facility, including packaging, labeling and availability of medications;
- (4) review the facility's procedures and records for the disposition of medications and provide assistance, if necessary;
- (5) provision of a written report of findings and any recommendations for change for Items (1) through (4) of Paragraph (a) of this Rule to the facility and the physician or appropriate health professional, when necessary;
- (6) conducting in-service programs as needed for facility staff on medication usage that includes, but not limited to the following:
 - (A) potential or current medication related problems identified;
 - (B) new medications;
 - (C) side effects and medication interactions; and
 - (D) policies and procedures.

(b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary.

(c) The facility shall maintain the findings and reports resulting from the activities in Subparagraphs (1) through (6) of Paragraph (a) of this Rule in the facility, including action taken by the facility.

*History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, 2000.*

10A NCAC 13G .1010 PHARMACEUTICAL SERVICES

(a) A family care home shall allow the residents the right to choose a pharmacy provider as long as the pharmacy provides services that are in accordance with requirements of this Section and all applicable state and federal regulations and the facility's medication management policies and procedures.

(b) There shall be a current, written agreement with a licensed pharmacist or a prescribing practitioner for pharmaceutical care services in accordance with Rule .1009 of this Section. The written agreement shall include a statement of the responsibility of each party.

(c) The facility shall assure the provision of pharmaceutical services to meet the needs of the residents including procedures that assure the accurate ordering, receiving and administering of all medications prescribed on a routine, emergency, or as needed basis.

(d) The facility shall assure the provision of medication for residents on temporary leave from the facility or involved in day activities out of the facility. The facility shall have written policies and procedures for a resident's temporary leave of absence. The policies and procedures shall facilitate safe administration by assuring that upon receipt of the medication for a leave of absence the resident or the person accompanying the resident is able to identify the medication, dosage, and administration time for each medication provided for the temporary leave of absence. The policies and procedures shall include at least the following provisions:

- (1) The amount of resident's medications provided shall be sufficient and necessary to cover the duration of the resident's absence. For the purposes of this Rule, sufficient and necessary means the amount of medication to be administered during the leave of absence or only a current dose pack, card, or container if the current dose pack, card, or container has enough medication for the planned absence;
- (2) Written and verbal instructions for each medication to be released for the resident's absence shall be provided to the resident or the person accompanying the resident upon the medication's release from the facility and shall include at least:
 - (A) the name and strength of the medication;
 - (B) the directions for administration as prescribed by the resident's physician;
 - (C) any cautionary information from the original prescription package if the information is not on the container released for the leave of absence;
- (3) The resident's medications shall be provided in a capped or closed container that will protect the medications from contamination and spillage; and
- (4) Labeling of each of the resident's individual medication containers for the leave of absence shall be legible, include at least the name of the resident and the name and strength of the medication, and be affixed to each container.

The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation of the quantities of medications released from and returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications' release from and return to the facility.

(e) The facility shall assure that accurate records of the receipt, use, and disposition of medications are maintained in the facility and available upon request for review.

*History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. July 1, 2005;
Amended Eff. April 1, 2015.*

SECTION .1100 – MANAGEMENT OF RESIDENT'S FUNDS AND REFUNDS

10A NCAC 13G .1101 MANAGEMENT OF RESIDENT'S FUNDS

(a) Residents shall manage their own funds if possible.

- (b) In situations where a resident is unable to manage his funds, a legal representative or payee shall be designated in accordance with Rule .1102 of this Section.
- (c) Residents shall endorse checks made out to them unless a legal representative or payee has been authorized to endorse checks.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 1984.

10A NCAC 13G .1102 LEGAL REPRESENTATIVE OR PAYEE

- (a) In situations where a resident of a family care home is unable to manage his funds, the administrator shall contact a family member or the county department of social services regarding the need for a legal representative or payee. The administrator and other staff of the home shall not serve as a resident's legal representative, payee, or executor of a will, except as indicated in Paragraph (b) of this Rule.
- (b) In the case of funds administered by the Social Security Administration, the Veteran's Administration or other federal government agencies, the administrator of the home may serve as a payee when so authorized as a legally constituted authority by the respective federal agencies.
- (c) The administrator shall give the resident's legal representative or payee receipts for any monies received on behalf of the resident.

History Note: Authority G.S. 35A-1203; 108A-37; 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 1984.

10A NCAC 13G .1103 ACCOUNTING FOR RESIDENT'S PERSONAL FUNDS

- (a) To document a resident's receipt of the State-County Special Assistance personal needs allowance after payment of the cost of care, a statement shall be signed by the resident or marked by the resident with two witnesses' signatures. The statement shall be maintained in the home.
- (b) Upon the written authorization of the resident or his legal representative or payee, an administrator or the administrator's designee may handle the personal money for a resident, provided an accurate accounting of monies received and disbursed and the balance on hand is available upon request of the resident or his legal representative or payee.
- (c) A record of each transaction involving the use of the resident's personal funds according to Paragraph (b) of this Rule shall be signed by the resident, legal representative or payee or marked by the resident, if not adjudicated incompetent, with two witnesses' signatures at least monthly verifying the accuracy of the disbursement of personal funds. The record shall be maintained in the home.
- (d) A resident's personal funds shall not be commingled with facility funds. The facility shall not commingle the personal funds of residents in an interest-bearing account.
- (e) All or any portion of a resident's personal funds shall be available to the resident or his legal representative or payee upon request during regular office hours, except as provided in Rule .1105 of this Subchapter.
- (f) The resident's personal needs allowance shall be credited to the resident's account within 24 hours of the check being deposited following endorsement.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. April 1, 1984;
Amended Eff. July 1, 2005; April 1, 1987.

10A NCAC 13G .1104 REFUND POLICY

A family care home's refund policy shall be in writing and signed by the administrator. A copy shall be given to the resident or the resident's responsible person at time of admission. A copy shall also be filed in the resident's record.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;

Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; July 1, 1990.

10A NCAC 13G .1105 REFUND OF PERSONAL FUNDS

- (a) When the administrator or the administrator's designee handles a resident's personal money at the resident's or his payee's request, the balance shall be given to the resident or the resident's responsible person within 14 days of the resident's leaving a family care home.
- (b) If a resident dies, the administrator of his estate or the Clerk of Superior Court, when no administrator for his estate has been appointed, shall be given all of his personal funds within 30 days after death.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 1984.

10A NCAC 13G .1106 SETTLEMENT OF COST OF CARE

- (a) If a resident of a family care home, after being notified by the home of its intent to discharge the resident in accordance with Rule .0705 of this Subchapter, moves out of the home before the period of time specified in the notice has elapsed, the home shall refund the resident an amount equal to the cost of care for the remainder of the month minus any nights spent in the home during the notice period. The refund shall be made within 14 days after the resident leaves the home.
- (b) If a resident moves out of the home without giving notice, as may be required by the home according to Rule .0705(h) of this Subchapter, or before the home's required notice period has elapsed, the resident owes the home an amount equal to the cost of care for the required notice period. If a resident receiving State-County Special Assistance moves without giving notice or before the notice period has elapsed, the former home is entitled to the required payment for the notice period before the new home receives any payment. The home shall refund the resident the remainder of any advance payment following settlement of the cost of care. The refund shall be made within 14 days from the date of notice or, if no notice is given, within 14 days of the resident leaving the home.
- (c) When there is an exception to the notice as provided in Rule .0705(h) of this Subchapter to protect the health or safety of the resident or others in the home, the resident is only required to pay for any nights spent in the home. A refund shall be made to the resident by the home within 14 days from the date of notice.
- (d) When a resident gives notice of leaving the home, as may be required by the home according to Rule .0705(h) of this Subchapter, and leaves at the end of the notice period, the home shall refund the resident the remainder of any advance payment within 14 days from the date of notice. If notice is not required by the home, the refund shall be made within 14 days after the resident leaves the home.
- (e) When a resident leaves the home with the intent of returning to it, the following apply:
- (1) The home may reserve the resident's bed for a set number of days with the written agreement of the home and the resident or his responsible person and thereby require payment for the days the bed is held.
 - (2) If, after leaving the home, the resident decides not to return to it, the resident or someone acting on his behalf may be required by the home to provide up to a 14-day written notice that he is not returning.
 - (3) Requirement of a notice, if it is to be applied by the home, shall be a part of the written agreement and explained by the home to the resident and his family or responsible person before signing.
 - (4) On notice by the resident or someone acting on his behalf that he will not be returning to the home, the home shall refund the remainder of any advance payment to the resident or his responsible person, minus an amount equal to the cost of care for the period covered by the agreement. The refund shall be made within 14 days after notification that the resident will not be returning to the home.
 - (5) In no situation involving a recipient of State-County Special Assistance may a home require payment for more than 30 days since State-County Special Assistance is not authorized unless the resident is actually residing in the home or it is anticipated that he will return to the home within 30 days.
 - (6) Exceptions to the two weeks' notice, if required by the home, are cases where returning to the home would jeopardize the health or safety of the resident or others in the home as certified by the resident's physician or approved by the county department of social services, and in the case of the resident's death. In these cases, the home shall refund the rest of any advance payment calculated beginning with the day the home is notified.

(f) If a resident dies, the administrator of his estate or the Clerk of Superior Court, when no administrator for his estate has been appointed, shall be given a refund equal to the cost of care for the month minus any nights spent in the home during the month. This is to be done within 30 days after the resident's death.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; June 1, 1987; April 1, 1984;
Temporary Amendment Eff. January 1, 2001;
Temporary Amendment Expired October 13, 2001;
Amended Eff. July 1, 2005.

SECTION .1200 – POLICIES, RECORDS AND REPORTS

10A NCAC 13G .1201 RESIDENT RECORDS

(a) The following shall be maintained on each resident in an orderly manner in the resident's record in the family care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services.

- (1) FL-2 or MR-2 Forms and patient transfer form or hospital discharge summary, when applicable;
- (2) Resident Register;
- (3) receipt for the following as required in Rule .0704 of this Subchapter:
 - (A) contract for services, accommodations and rates;
 - (B) house rules as specified in Rule .0704(2) of this Subchapter;
 - (C) Declaration of Residents' Rights (G.S. 131D-21);
 - (D) home's grievance procedures; and
 - (E) civil rights statement;
- (4) resident assessment and care plan;
- (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter;
- (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation;
- (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and
- (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged.

When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Items (1), (4), (5), (6) and (7) above may be sent with the resident.

(b) A resident financial record providing an accurate accounting of the receipt and disbursement of the resident's personal funds, if handled by the facility according to Rule .1103 of this Subchapter, shall be maintained on each resident in an orderly manner in the facility and be readily available for review by representatives of the Division of Health Service Regulation and county departments of social services. When there is an approved cluster of licensed facilities, financial records may be kept in one location among the clustered facilities

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1987; April 1, 1984;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005.

10A NCAC 13G .1202 TRANSFER OF RESIDENT'S RECORDS

At the request of the resident or his responsible person, copies of all pertinent information shall be given to the administrator of the licensed home to which the resident moves. The FL-2 or MR-2 shall be provided unless:

- (1) It was completed more than 90 days before the move; or
- (2) There has been an apparent change in the mental or physical condition of the resident.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 1990; April 1, 1984.

10A NCAC 13G .1203 DISPOSAL OF RESIDENT'S RECORDS

After a resident has left a family care home or died, the resident's records shall be filed in the home for at least one year and then stored for at least two more years.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. July 1, 2005; April 1, 1987; April 1, 1984.

10A NCAC 13G .1204 REPORT OF ADMISSIONS AND DISCHARGES

History Note: Authority G.S. 131D-2; 143B-153;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1992;
Repealed Eff. July 1, 2005.

10A NCAC 13G .1205 POPULATION REPORT

History Note: Authority G.S. 131D-2; 143B-153; 143B-165; S.L. 2002-160;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. May 1, 1992; April 1, 1984;
Temporary Repeal Eff. September 1, 2003;
Repealed Eff. June 1, 2004.

10A NCAC 13G .1206 HEALTH CARE PERSONNEL REGISTRY

The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .1001 and .1002.

History Note: Authority G.S. 131D-2.16; 131D-4.5; 131E-256; 143B-165;
Temporary Adoption Eff. January 1, 2000;
Eff. July 1, 2000.

10A NCAC 13G .1207 ADVERTISING

The administrator may use acceptable methods of advertising provided:

- (1) The name used is as it appears on the license.
- (2) Only the services and accommodations for which the home is licensed are used.
- (3) The home is listed under proper classification in telephone books, newspapers or magazines.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984.

10A NCAC 13G .1208 FACILITIES TO REPORT RESIDENT DEATHS

For purposes of this Section, facilities licensed in accordance with G.S. 131D-2 shall report resident deaths to the Division of Health Service Regulation.

History Note: Authority G.S. 131D-2.4; 131D-2.16; 131D-34.1; 143B-165;

*Temporary Adoption Eff. May 1, 2001;
Eff. July 18, 2002.*

10A NCAC 13G .1209 DEATH REPORTING PROCEDURES

(a) Upon learning of a resident death as described in Paragraphs (b) and (c) of this Rule, a facility shall file a report in accordance with this Rule. A facility shall be deemed to have learned of a resident death when any facility staff obtains information that the death occurred.

(b) A written notice containing the information listed under Paragraph (d) of this Rule shall be made immediately for the following:

- (1) a resident death occurring in an adult care home within seven days of the use of a physical restraint or physical hold on the resident; or
- (2) a resident death occurring within 24 hours of the resident's transfer from the adult care home to a hospital, if the death occurred within seven days of physical restraint or physical hold of the resident.

(c) A written notice containing the information under Paragraph (d) of this Rule shall be made within three days of any death resulting from violence, accident, suicide or homicide.

(d) Written notice may be submitted in person or by telefacsimile or electronic mail. If the reporting facility does not have the capacity or capability to submit a written notice immediately, the information contained in the notice may be reported by telephone following the same time requirements under Subparagraphs (b) and (c) of this Rule until such time the written notice may be submitted. The notice shall include at least the following information:

- (1) Reporting facility: Name, address, county, license number (if applicable), Medicare/Medicaid provider number (if applicable), facility administrator and telephone number, name and title of person preparing report, first person to learn of death and first staff to receive report of death, and date and time report prepared;
- (2) Resident information: Name, Medicaid number (if applicable), date of birth, age, sex, race, primary admitting diagnoses, and date of most recent admission to an acute care hospital.
- (3) Circumstances of death: place and address where resident died, date and time death was discovered, physical location decedent was found, cause of death (if known), whether or not decedent was restrained at the time of death or within 7 days of death and if so, a description of the type of restraint and its usage, and a description of events surrounding the death; and
- (4) Other information: list of other authorities such as law enforcement or the County Department of Social Services that have been notified, have investigated or are in the process of investigating the death or events related to the death.

(e) The facility shall submit a written report, using a form pursuant to G.S. 131D-34.1(e). The facility shall provide, fully and accurately, all information sought on the form. If the facility is unable to obtain any information sought on the form, or if any such information is not yet available, the facility shall so explain on the form.

(f) In addition, the facility shall:

- (1) Notify the Division of Health Service Regulation immediately whenever it has reason to believe that information provided may be erroneous, misleading, or otherwise unreliable;
- (2) Submit to the Division of Health Service Regulation, immediately after it becomes available, any information required by this rule that was previously unavailable; and
- (3) Provide, upon request by the Division of Health Service Regulation, other information the facility obtains regarding the death, including, but not limited to, death certificates, autopsy reports, and reports by other authorities.

(g) With regard to any resident death under circumstances described in G.S. 130A-383, a facility shall notify the appropriate law enforcement authorities so the medical examiner of the county in which the body is found may be notified. Documentation of such notification shall be maintained by the facility and be made available for review by the Division upon request.

(h) In deaths not under the jurisdiction of the medical examiner, the facility shall notify the decedent's next-of-kin, or other individual authorized according to G.S. 130A-398, that an autopsy may be requested as designated in G.S. 130A-389.

*History Note: Authority G.S. 131D-2.16; 131D-34.1; 143B-165;
Temporary Adoption Eff. May 1, 2001;
Eff. July 18, 2002.*

10A NCAC 13G .1210 DEFINITIONS APPLICABLE TO DEATH REPORTING

The following definitions shall apply throughout this Section:

- (1) "Accident" means an unexpected, unnatural or irregular event contributing to a resident's death and includes, but is not limited to, medication errors, falls, fractures, choking, elopement, exposure, poisoning, drowning, fire, burns, or thermal injury, electrocution, misuse of equipment, motor vehicle accidents, and natural disasters.
- (2) "Immediately" means at once, at or near the present time, without delay.
- (3) "Violence" means physical force exerted for the purpose of violating, damaging, abusing or injuring, or abusing another person.

*History Note: Authority G.S. 131D-2.16; 131D-34.1; 143B-165;
Temporary Adoption Eff. May 1, 2001;
Eff. July 18, 2002.*

10A NCAC 13G .1211 WRITTEN POLICIES AND PROCEDURES

(a) A family care home shall develop written policies and procedures that comply with applicable rules of this Subchapter, on the following:

- (1) ordering, receiving, storage, discontinuation, disposition, administration, including self-administration, and monitoring the resident's reaction to medications, as developed in consultation with a licensed health professional who is authorized to dispense or administer medications;
- (2) use of alternatives to physical restraints and the care of residents who are physically restrained, as developed in consultation with a registered nurse;
- (3) accident, fire safety and emergency procedures;
- (4) infection control;
- (5) refunds;
- (6) missing resident;
- (7) identification and supervision of wandering residents;
- (8) management of physical aggression or assault by a resident;
- (9) handling of resident grievances;
- (10) visitation in the facility by guests; and
- (11) smoking and alcohol use.

(b) In addition to other training and orientation requirements in this Subchapter, all staff shall be trained within 30 days of hire on the policies and procedures listed as Subparagraphs (3), (4), (6), (7), (8), (9), (10) and (11) in Paragraph (a) of this Rule.

(c) Policies and procedures on which staff have been trained shall be available within the facility to staff for their reference.

*History Note: Authority 131D-2.16; 143B-165;
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, 2005.*

10A NCAC 13G .1212 RECORD OF STAFF QUALIFICATIONS

A family care home shall maintain records of staff qualifications required by the rules in Section .0400 of this Subchapter in the facility. When there is an approved cluster of licensed facilities, these records may be kept in one location among the clustered facilities.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Temporary Adoption Eff. July 1, 2004;
Eff. July 1, 2005.*

10A NCAC 13G .1213 REPORTING OF ACCIDENTS AND INCIDENTS

(a) A family care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid.

(b) Notification as required in Paragraph (a) of this Rule shall be by a copy of the death report completed according to Rule .1208 of this Subchapter or a written report that shall provide the following information:

- (1) resident's name;
- (2) name of staff who discovered the accident or incident;
- (3) name of the person preparing the report;
- (4) how, when and where the accident or incident occurred;
- (5) nature of the injury;
- (6) what was done for the resident, including any follow-up care;
- (7) time of notification or attempts at notification of the resident's responsible person or contact person as required in Paragraph (e) of this Rule; and
- (8) signature of the administrator or administrator-in-charge.

(c) The report as required in Paragraph (b) of this Rule shall be submitted to the county department of social services by mail, telefacsimile, electronic mail, or in person within 48 hours of the initial discovery or knowledge by staff of the accident or incident.

(d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident.

(e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification:

- (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and
- (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter.

(f) When a resident is at risk that death or physical harm will occur as a result of physical violence by another person, the facility shall immediately report the situation to the local law enforcement authority.

(g) In the case of physical assault by a resident or whenever there is a risk that death or physical harm will occur due to the actions or behavior of a resident, the facility shall immediately:

- (1) seek the assistance of the local law enforcement authority;
- (2) provide additional supervision of the threatening resident to protect others from harm;
- (3) seek any needed emergency medical treatment;
- (4) make a referral to the Local Management Entity for Mental Health Services or mental health provider for emergency treatment of the threatening resident; and
- (5) cooperate with assessment personnel assigned to the case by the Local Management Entity for Mental Health Services or mental health provider to enable them to provide their earliest possible assessment.

(h) The facility shall immediately report any assault resulting in harm to a resident or other person in the facility to the local law enforcement authority.

History Note: Authority G.S. 131D-2.16; 143B-165;
Eff. July 1, 2005.

10A NCAC 13G .1214 AVAILABILITY OF CORRECTIVE ACTION AND SURVEY REPORTS

A family care home shall make available within the facility, upon request, corrective action reports by the county departments of social services and facility survey reports by state licensure consultants that have been approved by the Adult Care Licensure Section of the Division of Health Service Regulation within the past 12 months to residents and their families or responsible persons and to prospective residents and their families or responsible persons.

History Note: Authority 131D-2.16; 143B-165;
Eff. July 1, 2005.

SECTION .1300 - USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES

10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES

(a) A family care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be:

- (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes;
- (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule;
- (3) the least restrictive restraint that would provide safety;
- (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record.
- (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule;
- (6) applied correctly according to the manufacturer's instructions and the physician's order; and
- (7) used in conjunction with alternatives in an effort to reduce restraint use.

Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

(b) The facility shall ask the resident or resident's legal representative if the resident may be restrained based on an order from the resident's physician. The facility shall inform the resident or legal representative of the reason for the request and the benefits of restraint use and the negative outcomes and alternatives to restraint use. The resident or the resident's legal representative may accept or refuse restraints based on the information provided. Documentation shall consist of a statement signed by the resident or the resident's legal representative indicating the signer has been informed, the signer's acceptance or refusal of restraint use and, if accepted, the type of restraint to be used and the medical indicators for restraint use.

Note: Potential negative outcomes of restraint use include incontinence, decreased range of motion, decreased ability to ambulate, increased risk of pressure ulcers, symptoms of withdrawal or depression and reduced social contact.

(c) In addition to the requirements in Rule 13F .0801, .0802 and .0903 of this Subchapter regarding assessments and care planning, the resident assessment and care planning prior to application of restraints as required in Subparagraph (a)(5) of this Rule shall meet the following requirements:

- (1) The assessment and care planning shall be implemented through a team process with the team consisting of at least a staff supervisor or personal care aide, a registered nurse, the resident and the resident's responsible person or legal representative. If the resident or resident's responsible person or legal representative is unable to participate, there shall be documentation in the resident's record that they were notified and declined the invitation or were unable to attend.
- (2) The assessment shall include consideration of the following:
 - (A) medical symptoms that warrant the use of a restraint;
 - (B) how the medical symptoms affect the resident;
 - (C) when the medical symptoms were first observed;
 - (D) how often the symptoms occur;
 - (E) alternatives that have been provided and the resident's response; and
 - (F) the least restrictive type of physical restraint that would provide safety.
- (3) The care plan shall include the following:
 - (A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained;
 - (B) the type of restraint to be used; and
 - (C) care to be provided to the resident during the time the resident is restrained.

(d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule:

- (1) The order shall indicate:
 - (A) the medical need for the restraint;

- (B) the type of restraint to be used;
 - (C) the period of time the restraint is to be used; and
 - (D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and two hours for releases.
- (2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician of the order within seven days.
 - (3) The restraint order shall be updated by the resident's physician at least every three months following the initial order.
 - (4) If the resident's physician changes, the physician who is to attend the resident shall update and sign the existing order.
 - (5) In emergency situations, the administrator or administrator-in-charge shall make the determination relative to the need for a restraint and its type and duration of use until a physician is contacted. Contact with a physician shall be made within 24 hours and documented in the resident's record.
 - (6) The restraint order shall be kept in the resident's record.
- (e) All instances of the use of physical restraints and alternatives shall be documented by the facility in the resident's record and include the following:
- (1) restraint alternatives that were provided and the resident's response;
 - (2) type of restraint that was used;
 - (3) medical symptoms warranting restraint use;
 - (4) the time the restraint was applied and the duration of restraint use;
 - (5) care that was provided to the resident during restraint use; and
 - (6) behavior of the resident during restraint use.
- (f) Physical restraints shall be applied only by staff who have received training according to Rule .0506 of this Subchapter and been validated on restraint use according to Rule .0504 of this Subchapter.

History Note: Authority G.S. 131D-2.16; 143B-165;
 Temporary Adoption Eff. July 1, 2004;
 Temporary Adoption Expired March 12, 2005;
 Eff. June 1, 2005.

SECTION .1500 – ADMINISTRATOR APPROVAL AND RENEWAL

10A NCAC 13G .1501 ADMINISTRATOR APPROVAL

- (a) Each family care home shall have an administrator that has been approved by the Department pursuant to this Rule.
- (b) Applicant administrators shall meet the following qualifications:
 - (1) be 21 years of age or older;
 - (2) provide a satisfactory criminal background report by providing to the Department the submissions required by:
 - (A) the State Repository of Criminal Histories, if the applicant has been a resident of this State for five years or more; or
 - (B) both the State and National Repositories of Criminal Histories, if the applicant has been a resident of this State for less than five years;
 - (3) complete an approved administrator-in-training program listed on the website at <http://ncdhhs.gov/dhsr/acls/adminguidelines.html> and consisting of a minimum of 20 hours of instruction in N.C. Assisted Living laws and statutes, human resources, and business management, and a minimum of 100 hours of on-the-job training in an assisted living facility;
 - (4) complete with 75 percent accuracy a written examination administered by the Department within 12 months of completing the administrator-in-training program; and
 - (5) be at least a high school graduate or certified under the GED Program.
- (c) For the purpose of this Rule, a satisfactory criminal background report means:
 - (1) no conviction by any jurisdiction of a felony for which prison time was served unless rights of citizenship have been restored and all of the following have been considered and determined by the Department to allow approval:
 - (A) the date of conviction;
 - (B) the circumstances surrounding the committing of the crime, if known;

- (C) the nexus between the criminal conduct of the person and job duties; and
 - (D) the prison, jail, probation, parole, rehabilitation and employment records of the person since the date the crime was committed;
- (2) no conviction by any jurisdiction of a misdemeanor unless all terms of the judgment imposed for said misdemeanor have been met and the following have been considered and determined by the Department to allow approval:
- (A) the date of conviction;
 - (B) the circumstances surrounding the committing of the crime, if known;
 - (C) the nexus between the criminal conduct of the person and job duties; and
 - (D) the prison, jail, probation, parole, rehabilitation and employment records of the person since the date the crime was committed.

History Note: Authority G.S. 131D-2.16; 131D-4.3; 143B-165; Eff. April 1, 2017.

10A NCAC 13G .1502 ADVERSE ACTION ON ADMINISTRATOR APPROVAL

(a) The Department shall deny, suspend, or revoke the approval of an administrator if the administrator or applicant administrator:

- (1) has not completed the continuing education credits required by Rule .1503 of this Section;
- (2) has been convicted by any jurisdiction of a felony unless rights of citizenship have been restored and all of the following have been considered and determined by the Department to allow approval:
 - (A) the date of conviction;
 - (B) the circumstances surrounding the committing of the crime, if known;
 - (C) the nexus between the criminal conduct of the person and the duties of an administrator; and
 - (D) the prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed;
- (3) is convicted by any jurisdiction of a misdemeanor unless all terms of the judgment imposed for said misdemeanor have been met and the following have been considered and determined by the Department to allow approval:
 - (A) the date of conviction;
 - (B) the circumstances surrounding the committing of the crime, if known;
 - (C) the nexus between the criminal conduct of the person and the duties of an administrator; and
 - (D) the prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed;
- (4) was the administrator of an adult care home or family care home whose license was summarily suspended pursuant to G.S. 131D-2.7(c) or a notice of revocation of the facility's license was issued pursuant to G.S. 131D-2.7(b). In these circumstances, the Department shall take into consideration the length of time the administrator was serving in that capacity at the facility and the nexus between the reason for the summary suspension or revocation of the facility's license and the job duties of the administrator in deciding whether to deny, suspend, or revoke the approval of an administrator;
- (5) is unable to perform as administrator with reasonable skill and safety to residents by reason of any observable or documented condition, such as dementia or other disease or condition known to result in irreversible cognitive deterioration or drug or alcohol dependency, that impairs the individual in such a way that it endangers the health, safety, or welfare of residents;
- (6) tested positive for a controlled substance or refused to consent to drug testing according to G.S. 131D-45;
- (7) prior or subsequent to applying to be an administrator, has a finding on the North Carolina Health Care Personnel Registry pursuant to G.S. 131E-256; or
- (8) fails to report any arrest or conviction for a felony or misdemeanor to the Department within 10 days after such arrest or conviction.

(b) The Department shall suspend the approval of an administrator who has been arrested because of alleged criminal conduct, if the relationship between the alleged criminal conduct and the administrator's duties indicates a need to seek action in order to further protect facility residents pending adjudication by a court. Serving as an administrator while the administrator's approval is suspended shall be grounds for revocation of approval. Examples of criminal conduct the

Department may consider in relation to the administrator's duties include fraud, physical assault, theft, abuse, neglect, exploitation, and drug diversion.

History Note: Authority G.S. 131D-2.16; 131D-2.18; 131D-4.3; 143B-165;
Eff. April 1, 2017.

10A NCAC 13G .1503 RENEWAL OF ADMINISTRATOR APPROVAL

(a) The Department shall renew an administrator's approval at the end of the year following the year of initial approval if the administrator submits documentation of completed coursework related to long term care management or the care of aged and disabled persons dated and issued by the course provider after approval. The required number of hours or coursework shall be prorated by the Department based 30 hours of required continuing education biennially and the number of months from the date of the administrator's initial approval until June 30 of the next year following issuance.

(b) The Department shall continue to renew an administrator's approval biennially based on an expiration date of June 30. For each renewal following initial renewal the administrator shall submit documentation totaling 30 hours of completed coursework related to long term care management or the care of aged and disabled persons dated and issued by the course provider within the current two-year approval period.

(c) For the purposes of this Rule, examples of coursework related to long term care management or the care of aged and disabled persons include financial management, human resource management, medication administration, dementia care, diabetic care, managing aggressive behaviors, and infection control.

History Note: Authority G.S. 131D-2.16; 131D-4.3; 143B-165;
Eff. April 1, 2017.

SECTION .1600 – RATED CERTIFICATES

10A NCAC 13G .1601 SCOPE

(a) This Section applies to all licensed family care homes for two to six residents that have been in operation for more than one year.

(b) As used in this Section a "rated certificate" means a certificate issued to a family care home on or after January 1, 2009 and based on the factors contained in G.S. 131D-10.

History Note: Authority G.S. 131D-4.5; 131D-10;
Eff. July 3, 2008.

10A NCAC 13G .1602 ISSUANCE OF RATED CERTIFICATES

(a) A rated certificate shall be issued to a facility by the Division of Health Service Regulation within 45 days completion of a new rating calculation pursuant to Rule .1604 of this Subchapter.

(b) If the ownership of the facility changes, the rated certificate in effect at the time of the change of ownership shall remain in effect until the next annual survey or until a new certificate is issued pursuant to Rule .1604(b) of this Subchapter.

(c) The certificate and any worksheet the Division used to calculate the rated certificate shall be displayed in a location visible to the public.

(d) The facility may contest the rated certificate by requesting a contested case hearing pursuant to G.S. 150B. The rated certificate and any subsequent certificates remain in effect during any contested case hearing process.

History Note: Authority G.S. 131D-4.5; 131D-10;
Eff. July 3, 2008.

10A NCAC 13G .1603 STATUTORY AND RULE REQUIREMENTS AFFECTING RATED CERTIFICATES

The following Statutes and Rules comprise the standards that contribute to rated certificates:

- (1) G.S. 131D-21 Resident's Rights;
- (2) 10A NCAC 13G .0300 The Building;
- (3) 10A NCAC 13G .0700 Admission and Discharge Requirements;
- (4) 10A NCAC 13G .0800 Resident Assessment and Care Plan;

- (5) 10A NCAC 13G .0900 Resident Care and Services;
- (6) 10A NCAC 13G .1000 Medications; and
- (7) 10A NCAC 13G .1300 Use of Physical Restraints and Alternatives.

*History Note: Authority G.S. 131D-4.5; 131D-10;
Eff. July 3, 2008.*

10A NCAC 13G .1604 RATING CALCULATION

(a) Ratings shall be based on:

- (1) Inspections completed pursuant to G.S. 131D-2(b)(1a);
- (2) Statutory and Rule requirements listed in Rule .1603 of this Section;
- (3) Type A or uncorrected Type B penalty violations identified pursuant to G.S. 131D-34; and
- (4) Other items listed in Subparagraphs (c)(1) and (c)(2) of this Rule.

(b) The initial rating a facility receives shall remain in effect until the next inspection. If an activity occurs which results in the assignment of additional merit or demerit points, a new certificate shall be issued pursuant to Rule .1602(a) of this Section.

(c) The rating shall be based on a 100 point scale. Beginning with the initial rating and repeating with each annual inspection, the facility shall be assigned 100 points and shall receive merits or demerits, which shall be added or subtracted from the 100 points, respectively. The merits and demerits shall be assigned as follows:

(1) Merit Points

- (A) If the facility corrects citations of noncompliance with the statutes or rules listed in Rule .1603 of this Subchapter, which are not related to the identification of a Type A violation or an uncorrected Type B violation, the facility shall receive 1.25 merit points for each corrected deficiency;
- (B) If the facility receives citations on its annual inspection with no Type A or Type B violations and the rating from the annual inspection is one or zero stars, the facility may request Division of Health Service Regulation to conduct a follow-up inspection not less than 60 days after the date of the annual inspection. A follow-up inspection shall be completed depending upon the availability of Division of Health Service Regulation staff. As determined by the follow-up review, the facility shall receive 1.25 merit points for each corrected deficiency;
- (C) If the facility corrects the citation for which a Type A violation was identified, the facility shall receive 2.5 merit points and shall receive an additional 2.5 merit points following the next annual inspection if no further Type A violations are identified;
- (D) If the facility corrects a previously uncorrected Type B violation, the facility shall receive 1.25 merit points;
- (E) If the facility's admissions have been suspended, the facility shall receive 5 merit points if the suspension is removed;
- (F) If the facility participates in any quality improvement program pursuant to G.S. 131D-10, the facility shall receive 2.5 merit points;
- (G) If the facility receives NC NOVA special licensure designation, the facility shall receive 2.5 merit points;
- (H) On or after the effective date of this Rule, if the facility permanently installs a generator or has a contract with a generator provider to provide emergency power for essential functions of the facility, the facility shall receive 2 merit points. For purposes of this Section, essential functions mean those functions necessary to maintain the health or safety of residents during power outages greater than 6 hours. If the facility has an existing permanently installed generator or an existing contract with a generator provider, the facility shall receive 1 merit point for maintaining the generator in working order or continuing the contract with a generator provider; and
- (I) On or after the effective date of this Rule, if the facility installs automatic sprinklers in compliance with the North Carolina Building Code, the facility shall receive 3 merit points. If the facility has an existing automatic sprinkler, the facility shall receive 2 merit points for subsequent ratings for maintaining the automatic sprinklers in good working order.

(2) Demerit Points

- (A) For each citation of noncompliance with the statutes or rules listed in Rule .1603 of this Subchapter, the facility shall receive a demerit of 2 points. The facility shall receive demerit points only once for citations in which the findings are identical to those findings used for another citation;
- (B) For each citation of a Type A violation, the facility shall receive a demerit of 10 points;
- (C) For each citation of a Type B violation, the facility shall receive a demerit of 3.5 points and if the Type B violation remains uncorrected as the result of a follow-up inspection, the facility shall receive an additional demerit of 3.5 points;
- (D) If the facility's admissions are suspended, the facility shall receive a demerit of 10 points; however, if the facility's admissions are suspended pursuant to G.S. 131D-4.2, the facility shall not receive any demerit points; and
- (E) If the facility receives a notice of revocation against its license, the facility shall receive demerit of 31 points.

(d) Facilities shall be given a rating of zero to four stars depending on the score assigned pursuant to Paragraph (a), (b) or (c) of this Rule. Ratings shall be assigned as follows:

- (1) Four stars shall be assigned to any facility whose score is 100 points or greater on two consecutive annual inspections;
- (2) Three stars shall be assigned for scores of 90 to 99.9 points, or for any facility whose score is 100 points or greater on one annual inspection;
- (3) Two stars shall be assigned for scores of 80 to 89.9 points;
- (4) One star shall be assigned for scores of 70 to 79.9 points; and
- (5) Zero stars shall be assigned for scores of 69.9 points or lower.

History Note: Authority G.S. 131D-4.5; 131D-10;
Eff. July 3, 2008.

10A NCAC 13G .1605 CONTENTS OF RATED CERTIFICATE

- (a) The certificate shall contain a rating determined pursuant to Rule .1604 of this Subchapter.
- (b) The certificate or accompanying worksheet from which the score is derived shall contain a breakdown of the point merits and demerits by the factors listed in Rules .1603 and .1604(c) of this Subchapter in a manner that the public can determine how the rating was assigned and the factors that contributed to the rating.
- (c) The certificate shall be printed on the same type of paper that is used to print the facility's license.
- (d) The Division of Health Service Regulation shall issue the certificate pursuant to Rule .1602 of this Subchapter.

History Note: Authority G.S. 131D-4.5; 131D-10;
Eff. July 3, 2008.