STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL CARE COMMISSION QUARTERLY MEETING
DIVISION OF HEALTH SERVICE REGULATION
809 RUGGLES DRIVE, RALEIGH NC 27603
EDGERTON BUILDING
CONFERENCE ROOM – 026A
OR
TEAMS Video Conference: Click here to join the meeting
OR
Dial-IN: 1-984-204-1487 / Passcode: 554 792 503#

May 13, 2022 (Friday)
9:00 a.m.

Agenda

I. Meeting Opens – Roll Call

II. Chairman's Comments……Dr. John Meier

III. Public Meeting Statement……Dr. John Meier

This meeting of the Medical Care Commission is open to the public but is not a public hearing. Therefore, any discussion will be limited to members of the Commission and staff unless questions are specifically directed by the Commission to someone in the audience.

IV. Ethics Statement……Dr. John Meier

The State Government Ethics Act requires members to act in the best interest of the public and adhere to the ethical standards and rules of conduct in the State Government Ethics Act, including the duty to continually monitor, evaluate, and manage personal, financial, and professional affairs to ensure the absence of conflicts of interest.

V. North Carolina Board of Ethics Letter……Dr. John Meier

North Carolina Board of Ethics Letter was received for the following newly appointed member:

- Dr. Lisa Tolnitch (**See Exhibit A/1**)

VI. Approval of Minutes (Action Items)……...……..Dr. John Meier

- **February 11, 2022** (Medical Care Commission Quarterly Meeting) (**See Exhibit A**)
- **May 3, 2022** (Medical Care Commission Special Meeting) (**See Exhibit A/2**)

VII. Bond Program Activities……...……Geary W. Knapp

A. Quarterly Report on Bond Program (**See Exhibit B**)

B. Notices & Non-Action Items & Technical Rule Changes

Technical Change Rules Amended by Codifier: Five rules updated website addresses, effective April 1, 2022 (Licensing of Adult Care Home & Family Care Homes Rules)

February 15, 2022 – Duke Health Series 2006A; 2006B; 2006C (**Conversions**)

- Par Value Outstanding: $52,835,000 (Series 2006A)
  $52,845,000 (Series 2006B)
  $15,940,000 (Series 2006C)
- New Interest Rates & New Holding Periods

March 1, 2022 – Duke Health Series 2005A; 2005B; 2016B; 2016C (**Conversions**)

- Par Value Outstanding: $66,335,000 (Series 2005A)
  $21,470,000 (Series 2005B)
  $90,000,000 (Series 2016B)
  $90,000,000 (Series 2016C)
- New Interest Rates, New Holding Periods, & New Bank Holders

March 3, 2022 – Vidant Health Series 2022A (**Refunding Taxable Series 2019A**)

- Par Value Outstanding: $94,710,000
- Series 2022A is a tax-exempt bond

March 16, 2022 – Duke Health Series 2012B (**Conversion**)

- Par Value Outstanding: $12,345,000
- New Interest Rate & New Bank Holder

March 16, 2022 – United Methodist Ret. Homes Series 2014B (**Conversion**)

- Par Value Outstanding: $5,310,000
- New Interest Rate & New Bank Holder

May 4, 2022 – Cone Health Series 2001A; Series 2001B (**Partial Redemption**)

- Par Value Redeemed: $8,445,000 (Series 2001A)
  $8,445,000 (Series 2002B)
- Cash provided from sale of Women's Center

VIII. Bond Projects (Action Items)

A. Vidant Health (Greenville)…….……Geary Knapp

Compliance Summary:

- **No Violations of MCC Compliance policy**

1) Does Organization have a formal post tax issuance compliance policy?

   Yes; Vidant has a formal Tax Exempt Bond Policy that deals with post tax issuance compliance.

2) Who in the Organization will be designated to ensure appropriate compliance with the issuance?

   The Chief Financial Officer of Vidant Health is responsible for compliance.

3) What is the Organization's compliance monitoring plan?

   The organization uses the compliance checklist provided by Bond Counsel with each issue as the guide of what is required and the checklist is completed annually as well as the annual compliance checklist from the NC Medical Care Commission. Vidant reports and shows the compliance checklist to the Finance Committee of the Board on an annual basis.

4) How will the Organization report compliance deficiencies to leadership and the Board?

   The finance committee would hear from management of any deficiency at their meeting. The CEO of the system is on the Vidant Medical Center Board and would hear the same report the committee hears. In reality, the issue would be verbally communicated as soon as a deficiency is known by the CFO. The Finance Committee has in their charter oversight and approval over all bond issues.

Selected Application Information:

1) **Information from FY21 Audit of Vidant Health (9/30 Year End)** (In Thousands)**:**

Net Income	$ 170,635
Operating Revenue	$ 2,153,496
Operating Expenses	($ 2,133,958)
Net Cash provided by Operating Activities	$ 89,093
Unrestricted Cash	$ 156,604
Change in Cash	$ 44,736

2) Ratings:

Moody's – A2 / Outlook Stable

3) Community Benefits:

Community Benefits (FY21)	$255,282,435
Estimated Costs of Treating Bad Debt Patients	$57,624,374

4) Long Term Debt Service Coverage Ratios:

Actual FYE 2021	3.82
Forecasted FYE 2022	3.16
Forecasted FYE 2023	3.57
Forecasted FYE 2024	3.68
Forecasted FYE 2025	3.93
Forecasted FYE 2026	4.25

5) Transaction Participants:

Financial Advisor:	Ponder & Co.
Bond Counsel:	Womble Bond Dickinson (US) LLP
Bank Purchaser:	Bank of America Public Capital Corp
Bank Counsel:	Mark E. Raymond LLC
Trustee:	U.S. Bank, N.A.
Trustee Counsel:	McGuireWoods LLP
Borrower Counsel:	KL Gates LLP

6) Board Diversity:

VIDANT HEALTH

Male:	10
Female:	1
Total:	**11**

Caucasian:	9
African American:	2
Asian	1
Total:	**11**

VIDANT MEDICAL CENTER

Male:	15
Female:	5
Total:	**20**

Caucasian:	13
African American:	6
Asian:	1
Total:	**20**

(See Exhibit E for Bond Sale Approval Form)

Resolution: The Commission grants preliminary approval to a transaction for Vidant Health to (1) provide funds, to be used, together with other available funds, to refund the $50,000,000 North Carolina Medical Care Commission Health Care Facilities Revenue Bonds (University Health Systems of Eastern Carolina) Series 2011, outstanding in the amount of $37,360,000 and (2) provide funds, to be used, together with other available funds, to refund the $101,605,000 North Carolina Medical Care Commission Health Care Facilities Revenue Refunding Bonds (Vidant Health) Series 2013A, outstanding in the amount of $51,305,000 and (3) provide funds, to be used, together with other available funds, to refund the $112,000,000 North Carolina Medical Care Commission Health Care Facilities Revenue Refunding Bonds (Vidant Health) Series 2013B, outstanding in the amount of $60,415,000. The intent of the proposed Bond Issue is to refinance with a new variable rate index due to the cessation of LIBOR, as well as, reduce Vidant's exposure to renewal risk. The proposed transaction in its entirety will result in an estimated NPV savings of $1,611,819. The proposed transaction is in accordance with an application received as follows:

ESTIMATED SOURCES OF FUNDS

Cash and Negotiable Securities from Reserves	$ 555,340
Principal amount of bonds to be issued	149,080,000
Total Sources of Funds	**$149,635,340**

ESTIMATED USES OF FUNDS

Amount to refund Series 2015	$149,080,000
Accrued Interest	135,090
Financial Advisor Fee	149,500

Local Government Commission Fee	8,750
Trustee Fee	7,500
Trustee Counsel	10,500
Corporation Counsel	63,000
Bank Purchaser Counsel	35,000
Bond Counsel	146,000
Total Uses	**$149,635,340**

Tentative approval is given with the understanding that the governing board of Vidant Health accepts the following conditions:

1. The project will continue to be developed pursuant to the applicable Medical Care Commission guidelines.

2. Final financial feasibility must be determined prior to the issuance of bonds.

3. The project must, in all respects, meet requirements of G.S. § 13lA (Health Care Facilities Finance Act).

4. The Executive Committee of the Commission is delegated the authority to approve the issuance or conversion of bonds for this project and may approve the issuance or conversion of such greater amount principal amount of the loan 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%).

5. The bonds or notes shall be sold or converted in such a manner and upon such terms and conditions as will, in the sole judgment of the Executive Committee of the Commission, result in the lowest cost to the facility and its patients.

6. If public approval of the bonds is required for the purpose of Section 147(f) of the Internal Revenue Code of 1986, as amended ("Section 147(f)"), this tentative approval shall constitute the recommendation of the Commission that the Governor of the State of North Carolina (the "Governor") approve the issuance of such bonds, subject to the satisfaction of the requirements of Section 147(f) concerning the holding of a public hearing prior to the submission of such recommendation to the Governor.

7. The borrower will provide the Commission annually a copy of Schedule H of the IRS form 990 to demonstrate community benefits provided by the borrower.

8. The borrower will furnish, prior to the sale of or issuance of the bonds or notes or execution of the leases, evidence that it is in compliance with the covenants of all of its outstanding Medical Care Commission debt.

9. All health care facilities and services directly or indirectly owned or controlled by the health care organization, including physician practices, shall be available to Medicare and Medicaid patients with no limitations imposed as a result of the source of reimbursement.

Based on information furnished by applicant, the project is:

Financially Feasible: YES
Construction & Related Costs are Reasonable: N/A

B. **Forest at Duke** (Durham)…….Geary Knapp

Compliance Summary:

- **No Violation of MCC Compliance policy**

1) Does Organization have a formal post tax issuance compliance policy?

   Yes

2) Who in the Organization will be designated to ensure appropriate compliance with the issuance?

   Chief Financial Officer (Karen Henry)

3) What is the Organization's compliance monitoring plan?

   The CFO utilizes a compliance checklist and maintains a binder for each bond issuance with all documentation. The compliance monitoring plan encompasses monthly, quarterly, and annual procedures.

4) How will the Organization report compliance deficiencies to leadership and the Board?

   For immediacy purposes, an e-mail to the Leadership Team and Board Members would be sent. Compliance issues would be discussed at quarterly Board meetings and applicable Board Committee meetings, as well as weekly Leadership Team meetings.

Selected Application Information:

1) Information from FYE 2021 (9/30 Year End) Audit of The Forest at Duke, Inc.:

Net Income	$ 3,755,052
Operating Revenue	$ 25,194,234
Operating Expenses	($ 24,069,990)

Net Cash provided by Operating Activities	$ 5,952,174
Unrestricted Cash	$ 7,207,894
Change in Cash	$ 2,069,920

2) Ratings:

Fitch – 'BBB+'

3) Community Benefits (FYE 2021):

Per N.C.G.S § 105 – 5.5% (Eligible for 100% property tax exclusion)

- Total Community Benefits and Charity Care - $1,357,027

4) Long-Term Debt Service Coverage Ratios:

Actual FYE 2021	3.94
Forecasted FYE 2022	4.36
Forecasted FYE 2023	4.26
Forecasted FYE 2024	2.16
Forecasted FYE 2025	2.55
Forecasted FYE 2026	3.66

5) Transaction Participants:

Bond Counsel:	Robinson, Bradshaw, & Hinson, P.A.
Underwriter:	B.C. Ziegler and Company
Underwriter Counsel:	Parker Poe Adams & Bernstein LLP
Borrower Counsel:	Womble Bond Dickinson (US) LLP
Accountant (AUP Forecast):	Clifton Larson Allen
Bank Purchaser:	TBD
Bank Counsel:	TBD
Trustee:	U.S. Bank, N.A.
Trustee Counsel:	TBD

6) Board Diversity:

Male:	8
Female:	6
Total:	**14**

Caucasian:	10
Hispanic:	1
African American:	3
Total:	**14**

7) Diversity of Residents (360 Residents):

Male:	32%
Female:	68%
Total:	**100%**

Caucasian:	95%
African American/Asian/Indian/Other:	5%
Total:	**100%**

(See Exhibit F for Fee Schedule and Bond Sale Approval Form)

Resolution: The Commission grants preliminary approval for The Forest at Duke, Inc. project to provide funds to be used, together with other available funds, to ***construct*** a single five-story building (250,000 square feet) which includes:

- 71 independent living apartments
- Expanded Community Center
  - Connects existing Community Center to New Health Center
  - Contains dining, fitness area, classroom, multi-purpose rooms, clinic and office space

Capital expenditures for the new construction shall be included as listed below, all in accordance with a preliminary application, plans and specifications and participation as follows:

ESTIMATED SOURCES OF FUNDS

Principal amount of bonds to be issued	$ 82,530,000
Total Sources of Funds	**$ 82,530,000**

ESTIMATED USES OF FUNDS

Construction Contracts	$ 63,662,794
Architect Fees	1,995,250
Architect Reimbursables	50,000
Contingency	611,564
Moveable Equipment	885,092
Material Testing/Inspections	190,000
Moisture Intrusion	46,850
3rd Party Commissioning	58,400
Technology	32,300
Marketing	1,012,750
Surveys, Tests, Insurance, etc.	615,000
Bond Interest during Construction	7,215,000

Debt Service Reserve Fund	4,800,000
Underwriter Fee	500,000
Feasibility Fee	135,000
Accountant Fee	40,000
Rating Agency Fee	85,000
Local Government Commission Fee	8,750
Trustee Fee	12,500
Printing Costs	5,250
Placement Agent	148,500
Appraisal, Survey, Title Insurance	80,000
Bank Origination Fee	45,000
Bank Purchaser Counsel	45,000
Underwriter Counsel	75,000
Corporate Counsel	75,000
Bond Counsel	100,000
Total Uses	**$ 82,530,000**

Tentative approval is given with the understanding that the governing board of The Forest at Duke, Inc. accepts the following conditions:

1. The project will continue to be developed pursuant to the applicable Medical Care Commission guidelines.

2. Any required certificate of need must be in effect at the time of the issuance of the bonds or notes.

3. Final financial feasibility must be determined prior to the issuance of bonds.

4. The project must, in all respects, meet requirements of G.S. § 131A (Health Care Facilities Finance Act).

5. The Executive Committee of the Commission is delegated the authority to approve the issuance of bonds for this project and may approve the issuance of such greater principal amount of the loan 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%).

6. The bonds or notes shall be sold in such a manner and upon such terms and conditions as will, in the sole judgment of the Executive Committee of the Commission, result in the lowest cost to the facility and its residents.

7. If public approval of the bonds is required for the purpose of Section 147(f) of the Internal Revenue Code of 1986, as amended ("Section 147(f)"), this tentative approval shall constitute the recommendation of the Commission that the Governor of the State of North Carolina (the "Governor") approve the issuance of such bonds, subject to the satisfaction of the requirements of Section

147(f) concerning the holding of a public hearing prior to the submission of such recommendation to the Governor.

8. The borrower will comply with the Commission's Resolution: Community Benefits/Charity Care Agreement and Program Description for CCRCs as adopted.

9. The borrower will furnish, prior to the sale of or issuance of the bonds or notes or execution of the leases, evidence that it is in compliance with the covenants of all of its outstanding Medical Care Commission debt.

Based on information furnished by applicant, the project is:

Financially Feasible: YES
Construction & Related Costs are Reasonable: YES

IX. Old Business (Discuss Rules, Fiscal Note, & Comments Submitted) (Action Items)

A. Rules for Adoption

1. Licensing of Hospital Rules……....…..Nadine Pfeiffer & Azzie Conley

Readoption of fourteen rules following Periodic Review

- Rules: 10A NCAC 13B.3801, .3903, .4103, .4104, .4106, .4305, .4603, .4801, .4805, .5102, .5105, .5406, .5408, .5411
  (**See Exhibits C thru C-3**)

X. New Business (Discuss Rules & Fiscal Note) (Action Items)

A. Rules for Initiating Rulemaking Approval

1. Adult Care/Family Care Home Rules……..N. Pfeiffer & M. Lamphere

Readoption of two rules following Periodic Review (Phase 3.5)

- Rules: 10A NCAC 13F.0904 & 10A NCAC 13G .0904
  (**See Exhibits D thru D-3**)

XI. Refunding of Commission Bond Issues (Action Item)……..……Geary W. Knapp

Recommended:

WHEREAS the bond market is in a period of generally fluctuating interest rates, and

WHEREAS, in the event of decline of rates during the next quarter, refunding of certain projects could result in significant savings in interest expense thereby reducing the cost of health care to patients, and

WHEREAS, the Commission will not meet again until August 12, 2022 in Raleigh, North Carolina;

THEREFORE, BE IT RESOLVED; that the Commission authorize its Executive Committee to approve projects involving the refunding of existing Commission debt and amend previously approved projects to include refunding components only between this date and August 12, 2022. Refunding projects may include non-Commission debt, and non-material, routine capital improvement expenditures.

XII. Meeting Adjournment

Exhibit A

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL CARE COMMISSION QUARTERLY MEETING
DIVISION OF HEALTH SERVICE REGULATION
809 RUGGLES DRIVE, RALEIGH NC 27603
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Or
Via Microsoft Teams: Click here to join the meeting
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Via Teleconference: 1-984-204-1487 / Passcode: 440 605 374#

Friday, February 11, 2022

9:00 a.m.

Minutes

I. Meeting Attendance

MEMBERS PRESENT	MEMBERS ABSENT
John J. Meier, IV, M.D., Chairman Joseph D. Crocker, Vice-Chairman Sally B. Cone Paul R.G. Cunningham, M.D. Bryant C. Foriest Eileen C. Kugler, RN, MSN, MPH, FNP Ashley H. Lloyd, D.D.S. Karen E. Moriarty Stephen T. Morton Robert E. Schaaf, M.D. Neel G. Thomas, M.D. Jeffrey S. Wilson **DIVISION OF HEALTH SERVICE REGULATION STAFF** Mark Payne, Director, DHSR/Secretary, MCC Geary W. Knapp, JD, CPA, Assistant Secretary, MCC Jeff Harms, Acting Construction Chief, DHSR Kimberly Randolph, Attorney General's Office Nadine Pfeiffer, Rules Review Manager, DHSR	Kathy G. Barger John A. Fagg, M.D. Linwood B. Hollowell, III

Megan Lamphere, Chief, Adult Care Licensure Section Shalisa Jones, Adult Care Licensure Crystal Abbott, Auditor, MCC Kathy Larrison, Auditor, MCC Alice Creech, Executive Assistant, MCC **OTHERS PRESENT** Tommy Brewer, Ziegler Adam Garcia, Ziegler Robert Wernet, Deerfield Robert Chandler, Deerfield Matthew Sharpe, Deerfield Tom Akins, LeadingAge Leslie Roseboro, LeadingAge Anita Holt, LeadingAge Gwendolyn Crider, Consultant to LeadingAge Chris Taylor, LeadingAge Jeff Horton, NC Senior Living Association	

II. Chairman's Comments……..……..Dr. John Meier

The Chairman thanked everyone for attending the teleconference meeting and reminded Medical Care Commission Members to complete their State of Economic Interest (SEI) by April 15, 2022 and ethics education when due, which is every two years.

III. Public Meeting Statement……...…….Dr. John Meier

This meeting of the Medical Care Commission is open to the public but is not a public hearing. Therefore, any discussion will be limited to members of the Commission and staff unless questions are specifically directed by the Commission to someone in the audience.

IV. Ethics Statement……..…….……Dr. John Meier

The State Government Ethics Act requires members to act in the best interest of the public and adhere to the ethical standards and rules of conduct in the State Government Ethics Act, including the duty to continually monitor, evaluate, and manage personal, financial, and professional affairs to ensure the absence of conflicts of interest.

V. Approval of Minutes (Action Items)……..……..……..……..Dr. John Meier

- **November 5, 2021 (Medical Care Commission Quarterly Meeting) (See Exhibit A)**

- **November 18, 2021 (Executive Committee) –** To approve the final sale of bonds, the proceeds of which are to be loaned to Plantation Village, Inc. **(See Exhibit B/1)**

COMMISSION ACTION: *A motion was made to approve the minutes by Mrs. Sally Cone, seconded by Mrs. Eileen Kugler, and unanimously approved.*

VI. Bond Program Activities……..…...…...……Geary W. Knapp

A. Quarterly Report on Bond Program **(See Exhibit B)**
B. The following notices and non-action items were received by the Executive Committee:

January 31st, 2022 – WakeMed, Series 2012A (Redemption)
- Par Value Outstanding: $206,545,000
- Funds provided by: Taxable Bond Project ($300,000,000)

VII. Bond Project (Action Item)

1. Deerfield Episcopal Retirement Community, Inc. (Asheville)……..……...…Geary W. Knapp

Resolution: The Commission grants preliminary approval to Deerfield Episcopal Retirement, Inc. to provide funds to be used, together with other available funds, to ***construct*** the following:

- 114 Independent Living Apartments
- 26 Assisted Living Units
- 11 Skilled Nursing Units (13 beds)
- Parking Deck
- Renovations to the Wellness Center; Common Areas; Commons Buildings

Capital expenditures for the new construction shall be included as listed below, all in accordance with a preliminary application, plans and specifications and participation as follows:

ESTIMATED SOURCES OF FUNDS

Principal amount of bonds to be issued	$ 221,865,000
Total Sources	**$ 221,865,000**

ESTIMATED USES OF FUNDS

Construction Contracts	182,500,000
Construction Contingency (1% of Construction Contracts)	1,825,000
Land Acquisition	481,150
Site Utility Development	300,000
Architect Fees	5,394,000
Architect's Reimbursables	220,000
Moveable Equipment	2,598,371
Survey, Tests, Insurance	1,325,000
Consultant Fees (Legal/Commissioning/Proj. Mgmnt./CON/Signage)	1,450,000
DHSR Reimbursables (G.S. § 131-E-267)	150,000
CON Fee	50,000
Marketing	2,280,000
Bond Interest during Construction	20,547,103
Underwriter Discount/Placement Fee	1,792,493
Feasibility Study Fee	125,000
Accountant Fee	40,000

Corporation Counsel	45,000
Bond Counsel	140,000
Rating Agency	105,000
Trustee Fee & Counsel	15,000
Printing Cost	10,000
Local Government Commission	8,750
Underwriter Counsel	75,000
Title Insurance	200,000
Blue Sky Filing & Counsel	5,000
Bank Commitment Fee	94,568
Bank Counsel	50,000
Appraisal/Environmental/Etc.	38,565
Total Uses	**$ 221,865,000**

Tentative approval is given with the understanding that the governing board of Deerfield Episcopal Retirement, Inc. accepts the following conditions:

1. The project will continue to be developed pursuant to the applicable Medical Care Commission guidelines.

2. Any required certificate of need must be in effect at the time of the issuance of the bonds or notes.

3. Final financial feasibility must be determined prior to the issuance of bonds.

4. The project must, in all respects, meet requirements of G.S. § 131A (Health Care Facilities Finance Act).

5. The Executive Committee of the Commission is delegated the authority to approve the issuance of bonds for this project and may approve the issuance of such greater principal amount of the loan 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%).

6. The bonds or notes shall be sold in such a manner and upon such terms and conditions as will, in the sole judgment of the Executive Committee of the Commission, result in the lowest cost to the facility and its residents.

7. If public approval of the bonds is required for the purpose of Section 147(f) of the Internal Revenue Code of 1986, as amended ("Section 147(f)"), this tentative approval shall constitute the recommendation of the Commission that the Governor of the State of North Carolina (the "Governor") approve the issuance of such bonds, subject to the satisfaction of the requirements of Section 147(f) concerning the holding of a public hearing prior to the submission of such recommendation to the Governor.

8. The borrower will comply with the Commission's Resolution: Community Benefits/Charity Care Agreement and Program Description for CCRCs as adopted.

9. The borrower will furnish, prior to the sale of or issuance of the bonds or notes or execution of the leases, evidence that it is in compliance with the covenants of all of its outstanding Medical Care Commission debt.

Based on information furnished by applicant, the project is:

1.	Financially feasible	✓	Yes	_____	No	_____ N/A
2.	Construction and related costs are reasonable	✓	Yes	_____	No	_____ N/A

See Exhibit C and Exhibit F for Selected Application information and Presentation

COMMISSION ACTION: *A motion was made to approve the preliminary bond project for Deerfield by Mr. Joe Crocker, seconded by Mrs. Eileen Kugler, and unanimously approved.*

VIII. New Business (Discuss Rules & Fiscal Note) (Action Items)

A. Rules for Initiating Rulemaking Approval

1. **Adult Care Home/Family Care Home Rules**……...….Nadine Pfeiffer & Megan Lamphere

Readoption of twenty rules following Periodic Review; Amendment of 4 rules; Repeal of 1 rule (Phase 3) (Total of 25 rules)

- Rules: 10A NCAC 13F .0404, .0407, .0501, .0502, .0503, .0504, .0508, .0905, .1006, .1008, .1010, .1207
- Rules 10A NCAC 13G .0404, .0406, .0501, .0502, .0503, .0504, .0507, 0508, .0903, .0905, .1005, .1006, .1208

(See Exhibits D thru D/3)

COMMISSION ACTION: *A motion was made to approve the Adult Care Home/Family Care Home Rules by Mr. Bryant Foriest, seconded by Mrs. Eileen Kugler, and unanimously approved.*

IX. LeadingAge North Carolina (Presentation)..…….……..….....…..……..Tom Akins

Mr. Tom Akins, Ms. Anita Holt, Ms. Leslie Roseboro, and Ms. Gwendolyn Crider updated the Commission on LeadingAge's new efforts on diversity and inclusion.

X. Refunding of Commission Bond Issues (Action Item)..……...……...…...……..Geary W. Knapp

Recommended:

WHEREAS, the bond market is in a period of generally fluctuating interest rates, and

WHEREAS, in the event of decline of rates during the next quarter, refunding of certain projects could result in significant savings in interest expense thereby reducing the cost of health care to patients, and

WHEREAS, the Commission will not meet again until May 13, 2022 in Raleigh, North Carolina;

THEREFORE, BE IT RESOLVED; that the Commission authorize its Executive Committee to approve projects involving the refunding of existing Commission debt and amend previously approved projects to include refunding components only between this date and May 13, 2022. Refunding projects may include non-material, routine capital improvement expenditures.

COMMISSION ACTION: *A motion was made to authorize the Executive Committee to approve projects involving the refunding of existing Commission debt between this date and May 13, 2022 by Mr. Joe Crocker, seconded by Mrs. Eileen Kugler, and unanimously approved.*

XI. Meeting Adjournment

There being no further business the meeting was adjourned at 11:15 a.m.

Respectfully Submitted,

Geary W. Knapp, JD, CPA
Assistant Secretary

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

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or
VIDEO CONFERENCE (LINK: Click here to join the meeting)
or
DIAL-IN (1-984-204-1487 / Passcode: 664 691 807#)

Friday, November 5, 2021

9:00 a.m.

Minutes

I. Meeting Opens – Roll Call

MEMBERS PRESENT	MEMBERS ABSENT
John J. Meier, IV, M.D., Chairman Kathy G. Barger Sally B. Cone Paul R.G. Cunningham, M.D. Bryant C. Foriest Linwood B. Hollowell, III Anita L. Jackson, M.D. Eileen C. Kugler, RN, MSN, MPH, FNP Stephen T. Morton Robert E. Schaaf, M.D. Neel G. Thomas, M.D. Jeffrey S. Wilson **DIVISION OF HEALTH SERVICE REGULATION STAFF** Mark Payne, Director, DHSR/Secretary, MCC Emery Milliken, Deputy Director, DHSR Geary W. Knapp, JD, CPA, Assistant Secretary, MCC Jeff Harms, Acting Construction Chief, DHSR Bethany Burgon, Attorney General's Office	Joseph D. Crocker, Vice-Chairman John A. Fagg, M.D. Ashley H. Lloyd, D.D.S. Karen E. Moriarty

Kimberly Randolph, Attorney General's Office Nadine Pfeiffer, Rules Review Manager, DHSR Megan Lamphere, Chief, Adult Care Licensure Section Libby Kinsey, Asst. Chief, Adult Care Licensure Section Azzie Conley, Chief, Acute & Home Care Debbie McCarty, Nurse Consultant, Acute & Home Care Crystal Abbott, Auditor, MCC Alice Creech, Executive Assistant, MCC **OTHERS PRESENT** Alice Adams, Robinson Bradshaw & Hinson, PA Tommy Brewer, Ziegler Adam Garcia, Ziegler Jonathan Erickson, United Methodist Retirement Homes Ginger Lockamy, Albert Lockamy's wife Ginny Lockamy, Albert Lockamy's daughter Elizabeth Lockamy, Albert Lockamy's daughter	

II. Chairman's Comments……..Dr. John Meier

III. Public Meeting Statement…….Dr. John Meier

This meeting of the Medical Care Commission is open to the public but is not a public hearing. Therefore, any discussion will be limited to members of the Commission and staff unless questions are specifically directed by the Commission to someone in the audience.

IV. Ethics Statement…….……Dr. John Meier

The State Government Ethics Act requires members to act in the best interest of the public and adhere to the ethical standards and rules of conduct in the State Government Ethics Act, including the duty to continually monitor, evaluate, and manage personal, financial, and professional affairs to ensure the absence of conflicts of interest.

V. Resolution of Appreciation for the Life & Service of Albert F. Lockamy, Jr...……..……Dr. John Meier

(See Exhibit A/2)

The Chairman emphasized how dedicated and important our late Member Mr. Albert Lockamy was to the Commission. He named his many professional accomplishments, and then presented Mrs. Lockamy & daughters with a Resolution of Appreciation and the Order of the Long Leaf Pine. Several comments were made by Members of the Commission, staff, and his wife and daughters.

VI. Approval of Minutes (Action Items)……..……..……..Dr. John Meier

- **August 13, 2021 (Medical Care Commission Quarterly Meeting) (See Exhibit A)**
- **September 20, 2021 (Medical Care Commission Special Rules Meeting) (See Exhibit A/1)**

- **September 24, 2021 (Executive Committee) –** To authorize the sale of bonds, the proceeds of which are to be loaned to EveryAge, formerly known as United Church Homes and Services **(See Exhibit B/1)**

- **October 21, 2021 (Executive Committee)** – To grant preliminary approval for the refunding of United Methodist Retirement Homes, Inc. bonds **(See Exhibit B/2)**

COMMISSION ACTION: *A motion was made to approve the minutes by Dr. Paul Cunningham, seconded by Mrs. Sally Cone, and unanimously approved.*

VII. Bond Program Activities……..…...……Geary W. Knapp

A. Quarterly Report on Bond Program **(See Exhibit B)**
B. The following notices and non-action items were received by the Executive Committee:

September 29, 2021 – UNC Health Southeastern Series 2017A, 2017B, & 2012 (Redemption)
- Par Value Outstanding: $79,920,000
- Funds provided by: Public Finance Authority

October 29, 2021 – Depaul Series 2007A (Redemption)
- Par Value Outstanding: $15,305,000
- Funds provided by: Sale of properties

VIII. Bond Projects (Action Item)

A. United Methodist Retirement Homes, Inc. (Refunding)……...……..Geary W. Knapp

Resolution of the North Carolina Medical Care Commission Authorizing the Issuance of $81,345,000 North Carolina Medical Care Commission Taxable Retirement Facilities First Mortgage Revenue Refunding Bonds (The United Methodist Retirement Homes) Series 2021B and Future Tax-Exempt Bonds to be entitled Retirement Facilities First Mortgage Revenue Refunding Bonds (The United Methodist Retirement Homes) Series 2023B

WHEREAS, the North Carolina Medical Care Commission (the "Commission") is a commission of the Department of Health and Human Services of the State of North Carolina and is authorized under Chapter 131A of the General Statutes of North Carolina, as amended (the "Act"), to borrow money and to issue in evidence thereof bonds and notes for the purpose of providing funds to pay all or any part of the cost of financing or refinancing health care facilities; and

WHEREAS, The United Methodist Retirement Homes, Incorporated (the "Corporation") is a nonprofit corporation duly incorporated and validly existing under and by virtue of the laws of the State of North Carolina and is a "non-profit agency" within the meaning of the Act; and

WHEREAS, the Corporation has made application to the Commission for a loan, which will be

used for the purpose of providing funds, together with other available funds, to (1) refund all of the Commission's outstanding Retirement Facilities First Mortgage Revenue Refunding Bonds (The United Methodist Retirement Homes) Series 2013A (the "Series 2013A Bonds"); (2) refund all of the

Commission's outstanding Retirement Facilities First Mortgage Revenue and Revenue Refunding Bonds (The United Methodist Retirement Homes) Series 2017A (the "Series 2017A Bonds," and together with the Series 2013A Bonds, the "Prior Bonds"); and (3) pay certain expenses incurred in connection with the issuance of the Bonds (as defined below) by the Commission (collectively, the "Plan of Finance"); and

WHEREAS, the Plan of Finance is proposed to be funded through the (i) issuance by the Commission of its Taxable Retirement Facilities First Mortgage Revenue Refunding Bonds (The United Methodist Retirement Homes) Series 2021B (the "Series 2021B Taxable Bonds") and (ii) the future sale and issuance by the Commission of a series of tax-exempt bonds entitled the North Carolina Medical Care Commission Retirement Facilities First Mortgage Revenue Refunding Bonds (The United Methodist Retirement Homes) Series 2023B (the "Future Tax-Exempt Bonds," and together with the Series 2021B Taxable Bonds, the "Bonds") in an aggregate principal amount equal to the outstanding principal amount of the Series 2021B Taxable Bonds at the time of issuance of the Future Tax-Exempt Bonds for the purpose of refunding and redeeming the Series 2021B Taxable Bonds;

WHEREAS, the Commission has determined that the public will best be served by the proposed Plan of Finance and, by a resolution adopted on October 21, 2021, has approved the issuance of the Bonds, subject to compliance by the Corporation with the conditions set forth in such resolution, and the Corporation has complied with such conditions to the satisfaction of the Commission; and

WHEREAS, there have been presented to officers and staff of the Commission draft copies of the following documents (collectively, the "Transaction Documents") relating to the issuance of the Bonds:

(a) a Contract of Purchase relating to the Series 2021B Taxable Bonds, dated the date of delivery of the Series 2021B Taxable Bonds (the "Purchase Contract"), between BB&T Community Holdings Co. (the "Purchaser") and the Local Government Commission and approved by the Commission and the Corporation, pursuant to which the Purchaser will purchase the Series 2021B Taxable Bonds on the terms and conditions set forth therein;

(b) a Trust Agreement, dated as of December 1, 2021 (the "Trust Agreement"), between the Commission and U.S. Bank National Association, as bond trustee (the "Bond Trustee");

(c) a Loan Agreement, dated as of December 1, 2021 (the "Loan Agreement"), between the Commission and the Corporation;

(d) a Supplemental Indenture for Obligation No. 29, dated as of December 1, 2021 ("Supplement No. 29"), by and between the Corporation, The United Methodist Retirement Homes Foundation, Inc. (the "Foundation") and U.S. Bank National Association, as master trustee (the "Master Trustee") under the Second Amended and Restated Master Trust Indenture, dated as of December 1, 2017 (the "Master Indenture"), between the Corporation, the Foundation and the Master Trustee;

(e) Obligation No. 29, dated as of the date of issuance of the Series 2021B Taxable Bonds ("Obligation No. 29"), to be issued by the Corporation to the Commission;

(f) a Continuing Covenants Agreement dated as of December 1, 2021 (the "Covenants Agreement"), between the Corporation, the Foundation and the Purchaser;

(g) a Supplemental Indenture for Obligation No. 30 dated as of December 1, 2021 ("Supplement No. 30" and, collectively with Supplement No. 29, the "Supplements"), between the Corporation and the Master Trustee;

(h) Obligation No. 30, dated as of the date of issuance of the Series 2021B Taxable Bonds ("Obligation No. 30" and, collectively with Obligation No. 29, the "Obligations"), to be issued by the Corporation to the Purchaser;

(i) Forward Purchase Option Agreement, to be dated as of December 1, 2021 (the "Forward Purchase Agreement"), among the Local Government Commission, the Commission, the Corporation and the Purchaser, relating to the Future Tax-Exempt Bonds;

(j) Escrow Deposit Agreement, dated as of December 1, 2021 (the "2013A Escrow Agreement"), among the Commission, the Corporation and U.S. Bank National Association, as escrow agent (the "2013 Escrow Agent"), relating to the refunding of the Series 2013A Bonds;

(k) Escrow Deposit Agreement, dated as of December 1, 2021 (the "2017A Escrow Agreement," and together with the 2013A Escrow Agreement, the "Escrow Agreements"), among the Commission, the Corporation and U.S. Bank National Association, as escrow agent (the "2017A Escrow Agent"), relating to the refunding of Series 2017A Bonds; and

(l) three First Amendments, each dated as of December 1, 2021, to each of the three Second Amended and Restated Deeds of Trust, Assignment of Rents, Security Agreement and Fixture Filing, each dated as of December 1, 2017 (as amended, the "Corporation Deeds of Trust") and each from the Corporation to the trustee named therein for the benefit of the Master Trustee; and

WHEREAS, the Commission has determined that the Corporation is financially responsible and capable of fulfilling its obligations under the Loan Agreement, the Master Indenture, Supplement No. 29 and Obligation No. 29; and

WHEREAS, the Commission has determined that adequate provision has been made for the payment of the principal of, redemption premium, if any, and interest on the Bonds;

NOW, THEREFORE, THE NORTH CAROLINA MEDICAL CARE COMMISSION DOES HEREBY RESOLVE, as follows:

Section 1. Capitalized words and terms used in this Resolution and not defined herein shall have the same meanings in this Resolution as such words and terms are given in the Master Indenture, the Trust Agreement and the Loan Agreement.

Section 2. Pursuant to the authority granted to it by the Act, the Commission hereby authorizes (a) the issuance of the Series 2021B Taxable Bonds in the aggregate principal amount of $81,345,000 and (b) the issuance of the Future Tax-Exempt Bonds in an aggregate principal amount equal to the outstanding principal amount of the Series 2021B Taxable Bonds at the time of issuance of the Future Tax-Exempt Bonds for the purpose of refunding and redeeming the Series 2021B Taxable Bonds. The Bonds shall mature on October 1, 2047. The Bonds shall bear interest at such rates determined in

accordance with the Trust Agreement and shall be subject to Sinking Fund Requirements set forth in Schedule 1 hereto. During the initial Direct Purchase Rate Period (which is fifteen years), the Bonds will

bear interest as set forth in Schedule 1 hereto, subject to adjustment under certain circumstances (e.g., taxability, event of default, corporate tax rate adjustments).

The Bonds shall be issued as fully registered bonds in (i) denominations of $100,000 and any integral multiple of $5,000 in excess of $100,000 during any Direct Purchase Rate Period or Weekly Rate Period (provided, however, Bonds bearing interest at the Direct Purchase Rate may be initially issued to, and purchased by, the Purchaser in any principal amount) and (ii) denominations of $5,000 and any integral multiples thereof during any Long-Term Rate Period or Adjustable Rate Period. While bearing interest at the Weekly Rate, Long-Term Rate or Adjustable Rate, the Bonds shall be issuable in book-entry form as provided in the Trust Agreement. Interest on the Bonds shall be paid at the times and at the rates determined as specified in the Trust Agreement. Payments of principal of and interest on the Bonds shall be made to the registered owners of the Bonds in such manner as is set forth in the Trust Agreement.

Section 3. The Bonds shall be subject to (i) optional redemption, extraordinary optional redemption and mandatory redemption, (ii) during any Weekly Rate Period or Adjustable Rate Period, optional tender for purchase, and (iii) mandatory tender for purchase, all at the times, upon the terms and conditions, and at the prices set forth in the Trust Agreement.

Section 4. The proceeds of the Series 2021B Taxable Bonds shall be applied as provided in Section 2.10 of the Trust Agreement. The Commission hereby finds that the use of the proceeds of the Bonds for a loan to refund the outstanding Prior Bonds and pay certain costs of issuing the Bonds will accomplish the public purposes set forth in the Act. The Commission hereby finds that the use of the proceeds of the Future Tax-Exempt Bonds for a loan to refund the outstanding Series 2021B Taxable Bonds will accomplish the public purposes set forth in the Act.

Section 5. The forms, terms and provisions of the Trust Agreement, the Loan Agreement and the Escrow Agreements are hereby approved in all respects, and the Chairman or Vice Chairman (or any other member of the Commission designated by the Chairman) and the Secretary or any Assistant Secretary of the Commission are hereby authorized and directed to execute and deliver the Trust Agreement, the Loan Agreement and the Escrow Agreements in substantially the forms presented, together with such changes, modifications and deletions as they, with the advice of counsel, may deem necessary and appropriate, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 6. The form, terms and provisions of the Purchase Contract and the Forward Purchase Agreement are hereby approved in all respects, and the Chairman, Vice Chairman (or any other member of the Commission designated by the Chairman), Secretary or any Assistant Secretary of the Commission are hereby authorized and directed to execute and deliver the Purchase Contract and the Forward Purchase Agreement in substantially the forms presented, together with such changes, modifications, insertions and deletions as they, with the advice of counsel, may deem necessary and appropriate, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 7. The form of the Bonds set forth in the Trust Agreement is hereby approved in all respects, and the Chairman or Vice Chairman (or any other member of the Commission designated by the Chairman) and the Secretary or any Assistant Secretary of the Commission are hereby authorized and directed to execute, by manual or facsimile signature as provided in such form of the Bonds, and to deliver

to the Bond Trustee for authentication on behalf of the Commission, the Bonds in definitive form, which shall be in substantially the form presented, together with such changes, modifications and deletions as

they, with the advice of counsel, may deem necessary, appropriate and consistent with the Trust Agreement, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 8. The forms of the Supplements, the Obligations, the Corporation Deeds of Trust and the Covenants Agreement are hereby approved in substantially the forms presented, together with such changes, modifications, insertions and deletions as the Chairman, Vice Chairman (or any other member of the Commission designated by the Chairman), Secretary or any Assistant Secretary of the Commission, with the advice of counsel, may deem necessary and appropriate, and the execution and delivery of the Trust Agreement by the Commission shall be conclusive evidence of the approval of the documents listed in this Section by the Commission.

Section 9. The Commission hereby approves the action of the Local Government Commission authorizing the private sale of the Series 2021B Taxable Bonds and the Future Tax-Exempt Bonds to the Purchaser in accordance with the Contract of Purchase and the Forward Purchase Agreement, respectively, at the purchase price of 100% of the principal amount thereof.

Section 10. Upon their execution in the form and manner set forth in the Trust Agreement, the Series 2021B Taxable Bonds shall be deposited with the Bond Trustee for authentication, and the Bond Trustee is hereby authorized and directed to authenticate the Series 2021B Taxable Bonds and, upon the satisfaction of the conditions set forth in Section 2.10 of the Trust Agreement, the Bond Trustee shall deliver the Series 2021B Taxable Bonds to the Purchaser, against payment therefor. Upon their execution in the form and manner set forth in the Trust Agreement, the Future Tax-Exempt Bonds shall be deposited with the Bond Trustee for authentication, and the Bond Trustee is hereby authorized and directed to authenticate the Future Tax-Exempt Bonds and, upon the satisfaction of the conditions set forth in Section 2.14 of the Trust Agreement, the Bond Trustee shall deliver the Future Tax-Exempt Bonds to the Purchaser, against payment therefor.

Section 11. U.S. Bank National Association is hereby appointed as the initial Bond Trustee for the Bonds.

Section 12. If the Bonds are converted to an interest rate other than the Direct Purchase Rate, the Depository Trust Company, New York, New York is hereby appointed as the initial Securities Depository for the Bonds, with Cede & Co., a nominee thereof, being the initial Securities Depository Nominee and initial registered owner of the Bonds.

Section 13. S. Mark Payne, Secretary of the Commission, Geary W. Knapp, Assistant Secretary of the Commission, and Kathy C. Larrison and Crystal Watson-Abbott, Auditors for the Commission, are each hereby appointed a Commission Representative as that term is defined in the Loan Agreement, with full power to carry out the duties set forth therein.

Section 14. The Chairman, Vice Chairman (or any other member of the Commission designated by the Chairman), Secretary and any Assistant Secretary of the Commission are authorized and directed (without limitation except as may be expressly set forth herein) to take such action and to execute and deliver any such documents, certificates, undertakings, agreements or other instruments as they, with the advice of counsel, may deem necessary or appropriate to effect the transactions contemplated by the Trust

agreement, the Loan Agreement, the Purchase Contract and the Forward Purchase Agreement, including, but not limited to, any amendments to the Transaction Documents required in connection with the issuance of the Future Tax-Exempt Bonds.

Section 15. This Resolution shall take effect immediately upon its passage.

Schedule 1
Sinking Fund Requirements

Due October 1	Amount	Due October 1	Amount
2022	$ 350,000	2035	$3,000,000
2023	3,190,000	2036	3,020,000
2024	3,120,000	2037	2,595,000
2025	5,110,000	2038	2,660,000
2026	2,840,000	2039	2,725,000
2027	2,895,000	2040	2,800,000
2028	3,020,000	2041	2,875,000
2029	3,080,000	2042	2,945,000
2030	3,195,000	2043	3,020,000
2031	3,295,000	2044	3,100,000
2032	3,310,000	2045	3,185,000
2033	3,825,000	2046	3,255,000
2034	2,415,000	2047*	6,520,000

* Maturity

Interest Rates

Taxable Interest Rate: Daily Simple SOFR plus 1.35%
Future Tax-Exempt Interest Rate: 79% of Daily Simple SOFR plus 1.0665%

Professional Fees Comparison for
The United Methodist Retirement Homes, Incorporated
Series 2021B and Future Tax-Exempt Bonds

Professional	Fees Estimated In Preliminary Approval Resolution	Actual Fees
Placement fee	$406,039	$386,388.75
Swap advisor	75,000	75,000.00
Verification agent	5,000	2,750.00
Corporation counsel	35,000	45,000.00
Bond counsel*	95,000	85,000.00
Purchaser commitment fee	101,469	101,681.25
Purchaser counsel fee	50,000	45,000.00
Trustee and trustee counsel fee	15,000	7,500.00

*Includes estimated amount for fees in connection with the issuance of the Future Tax-Exempt Bonds in 2023 (opinions, tax due diligence, closing certificates, etc.)

(See Exhibit E for Bond Sale Approval Form)

***COMMISSION ACTION**: A motion was made to approve the refunding by Mr. Bryant Foriest, seconded by Mrs. Eileen Kugler, and unanimously approved.*

IX. Old Business (Discuss Rules, fiscal note, and comments submitted) (Action Items)

A. Rules for Adoption

1. **Adult Care Home/Family Care Home Rules**……..….Nadine Pfeiffer & Megan Lamphere

Readoption of four rules following Periodic Review; Amendment of one rule (Phase 2.5)

- Rules: 10A NCAC 13F .0405, .0509, 1213; 10A NCAC 13G .0509, .1214.
  (See Exhibits C thru C/3)

***COMMISSION ACTION:** A motion was made to approve the Adult Care Home/Family Care Hone Rules by Mr. Bryant Foriest, seconded by Mrs. Kathy Barger, and unanimously approved.*

X. **New Business** (Discuss Rules & Fiscal Note) (Action Items)

A. Rules for Initiating Rulemaking Approval

1. **Licensing of Hospital Rules** ……..…..…...…….Nadine Pfeiffer & Azzie Conley

Readoption of fourteen rules following Periodic Review

- Rules: 10A NCAC 13B .3801, .3903, .4103, .4104, .4106, .4305, .4603, .4801, .4805, .5102, .5105, .5406, .5408, .5411 **(See Exhibits D thru D/2)**

COMMISSION ACTION: *A motion was made to approve the hospital rules by Mrs. Eileen Kugler, seconded by Dr. Paul Cunningham, and unanimously approved.*

XI. **Adoption of NCMCC Quarterly Meeting Dates for 2022** (Action Item)……...Dr. John Meier

February 10-11, 2022
May 12-13, 2022
August 11-12, 2022
November 3-4, 2022

COMMISSION ACTION: *A motion was made to approve the Quarterly Meeting Dates for 2022 by Mrs. Sally Cone, seconded by Mr. Bryant Foriest, and unanimously approved.*

XII. **Refunding of Commission Bond Issues** (Action Item)..…….……..…...……..Geary W. Knapp

Recommended:

WHEREAS, the bond market is in a period of generally fluctuating interest rates, and

WHEREAS, in the event of decline of rates during the next quarter, refunding of certain projects could result in significant savings in interest expense thereby reducing the cost of health care to patients, and

WHEREAS, the Commission will not meet again until February 11, 2022 in Raleigh, North Carolina;

THEREFORE, BE IT RESOLVED; that the Commission authorize its Executive Committee to approve projects involving the refunding of existing Commission debt and amend previously approved projects to include refunding components only between this date and February 11, 2022. Refunding projects may include non-material, routine capital improvement expenditures.

COMMISSION ACTION*: A motion was made to authorize the Executive Committee to approve projects involving the refunding of existing Commission debt between this date and February 11, 2022 by Dr. Paul Cunningham, seconded by Mrs. Kathy Barger, and unanimously approved.*

XIII. **Appointment of Three Executive Committee Members** (Action Item)……..……..Dr. John Meier

In accordance with 10A NCAC 13A. .0101, three members of the Executive Committee shall be appointed by a vote of the Commission of each odd year at its meeting in November. No member of the Executive Committee, except the Chairman and Vice-Chairman, shall serve more than two two-year

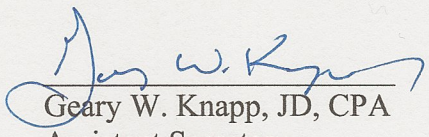
terms in succession. The terms of the three elected/appointed Executive Committee Members will expire 12/31/2023.

COMMISSION ACTION: *Mr. Bryant Foriest, Mr. Linwood Hollowell, and Mr. Jeffrey Wilson were unanimously appointed to a two-year term on the Executive Committee, which will expire on 12/31/ 2023.*

XIV. Meeting Adjournment

There being no further business the meeting was adjourned at 10:00 a.m.

Respectfully Submitted,



Geary W. Knapp, JD, CPA
Assistant Secretary

NC Medical Care Commission

Quarterly Report on **Outstanding Debt** (End: 2nd Quarter FYE 2022)

Program Measures	FYE 2021 Ending: 6/30/2021	FYE 2022 Ending: 12/31/2021
Outstanding Debt	**$5,458,749,746**	**$5,373,828,343**
Outstanding Series	**126**[1]	**124**[1]

Detail of Program Measures	Ending: 6/30/2021	Ending: 12/31/2021
Outstanding Debt per Hospitals and Healthcare Systems	$3,987,631,982	$3,860,845,637
Outstanding Debt per CCRCs	$1,416,747,763	$1,512,982,706
Outstanding Debt per Other Healthcare Service Providers	$54,370,000	$0
Outstanding Debt Total	**$5,458,749,746**	**$5,373,828,343**
Outstanding Series per Hospitals and Healthcare Systems	68	65
Outstanding Series per CCRCs	56	59
Outstanding Series per Other Healthcare Service Providers	2	0
Series Total	**126**	**124**
Number of Hospitals and Healthcare Systems with Outstanding Debt	14	14
Number of CCRCs with Outstanding Debt	17	18
Number of Other Healthcare Service Providers with Outstanding Debt	1	0
Facility Total	32	32

Exhibit B (Outstanding Balance)

B - 1

Note 1: For FYE 2022, NCMCC has closed 16 **Bond Series**. Out of the closed Bond Series: 2 were conversions, 6 were new money projects, 1 combination of new money project and refunding, and 7 were refundings. The Bond Series outstanding from FYE 2021 to current represents all new money projects, refundings, conversions, and redemptions.

GENERAL NOTES: Facility Totals represent a parent entity total and do not represent each individual facility owned/managed by the parent entity. CCRCs are licensed by the NC Department of Insurance. "Other Healthcare Service Providers" would include nursing homes, rehabilitation facilities, assisted living, blood donation centers, and hospice facilities. The following parent entities represent the current "other healthcare service providers" with outstanding NC MCC debt: NONE AT THIS TIME

NC Medical Care Commission

Quarterly Report on **History** of NC MCC Finance Act Program (End: 2nd Quarter FYE 2022)

Program Measures	FYE 2021 Ending: 6/30/2021	FYE 2022 Ending: 12/31/2021
Total PAR Amount of Debt Issued	**$27,586,164,692**	**$28,019,194,976**
Total Project Debt Issued (excludes refunding/conversion proceeds) [1]	**$13,433,214,540**	**$13,534,564,090**
Total Series Issued	**665**	**681**

Detail of Program Measures	Ending: 6/30/2021	Ending: 12/31/2021
PAR Amount of Debt per Hospitals and Healthcare Systems	$22,123,409,855	$22,223,409,855
PAR Amount of Debt per CCRCs	$5,088,459,607	$5,421,489,890
PAR Amount of Debt per Other Healthcare Service Providers	$374,295,230	$374,295,230
Par Amount Total	**$27,586,164,692**	**$28,019,194,976**
Project Debt per Hospitals and Healthcare Systems	$10,273,019,674	$10,273,019,674
Project Debt per CCRCs	$2,913,180,952	$3,014,530,502
Project Debt per Other Healthcare Service Providers	$247,013,915	$247,013,915
Project Debt Total	**$13,433,214,540**	**$13,534,564,090**
Series per Hospitals and Healthcare Systems	414	416
Series per CCRCs	212	226
Series per Other Healthcare Service Providers	39	39
Series Total	**665**	**681**
Number of Hospitals and Healthcare Systems issuing debt	99	99
Number of CCRCs issuing debt	40	41
Number of Other Healthcare Service Providers issuing debt	46	46
Facility Total	185	186

Note 1: Project Debt excludes bond proceeds that directly refunded prior NCMCC outstanding issues and conversion par amounts. Project Debt is an accumulation of all new project money, issuance costs (including issuance costs for refundings/conversions (if any)), and refundings of non-NCMCC debt.

GENERAL NOTES: Facility Totals represent each individual facility and <u>do not</u> represent parent entity totals. CCRCs are licensed by the NC Department of Insurance. "Other Healthcare Service Providers" would include nursing homes, rehabilitation facilities, assisted living, blood donation centers, and hospice facilities.

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

The North Carolina Medical Care Commission
809 Ruggles Drive
Raleigh, North Carolina

MINUTES

CALLED MEETING OF THE EXECUTIVE COMMITTEE CONFERENCE TELEPHONE MEETING ORIGINATING FROM THE COMMISSION'S OFFICE November 18, 2021 11:30 A.M.

Minutes

Members of the Executive Committee Present:

John J. Meier, IV, Chairman
Joseph D. Crocker, Vice-Chairman
Sally B. Cone
Bryant C. Foriest
Linwood B. Hollowell, III
Eileen C. Kugler
Jeffrey S. Wilson

Members of the Executive Committee Absent:

None

Members of Staff Present:

Geary W. Knapp, JD, CPA, Assistant Secretary
Crystal Watson-Abbott, Auditor, MCC
Kathy C. Larrison, Auditor, MCC
Alice S. Creech, Executive Assistant

Others Present:

Alice Adams, Robinson Bradshaw & Hinson, PA
Charles Bowyer, Robinson Bradshaw & Hinson, PA
Cara Arrans, Plantation Village
Melissa Messina, HJ Simms

1. **Purpose of meeting**
   To approve the final sale of bonds for Plantation Village, Inc.

2. **Resolution of the North Carolina Medical Care Commission Authorizing the Issuance of $32,740,000 North Carolina Medical Care Commission Retirement Facilities First Mortgage Revenue and Refunding Revenue Bonds (Plantation Village, Inc.) Series 2021A and $31,916,000 North Carolina Medical Care Commission Retirement Facilities First Mortgage Revenue Bonds (Plantation Village, Inc.) Series 2021B**

Executive Committee Action: *A motion was made to approve the resolution by Mr. Joe Crocker, seconded by Mr. Bryant Foriest, and unanimously approved.*

WHEREAS, the North Carolina Medical Care Commission (the "Commission") is a commission of the Department of Health and Human Services of the State of North Carolina and is authorized under Chapter 131A of the General Statutes of North Carolina, as amended (the "Act"), to borrow money and to issue in evidence thereof bonds and notes for the purpose of providing funds to pay all or any part of the cost of financing or refinancing health care facilities; and

WHEREAS, Plantation Village, Inc. (the "Corporation") is a nonprofit corporation duly incorporated and validly existing under and by virtue of the laws of the State of North Carolina and is a "non-profit agency" within the meaning of the Act; and

WHEREAS, the Corporation has made application to the Commission for one or more loans, which will be used for the purpose of providing funds, together with other available funds, to (1) finance the expansion and renovation of the Corporation's continuing care retirement center located at 1200 Porters Neck Road, Wilmington, North Carolina 28411 (the "Community"), including, but not limited to, constructing and equipping approximately 44 new independent living apartments and related common areas, renovating various dining facilities and resident activity spaces, upgrading informational technology systems throughout the Community, relocating maintenance facilities and creating and improving outdoor spaces such as gardens and a dog park (the "2021 Project"); (2) refund certain taxable indebtedness that was used to pay for an expansion of the Community, including the addition of 27 independent living apartments, a new wellness center and indoor pool, a new auditorium, and renovation of the main common areas and dining room (the "Prior Project" and, together with the 2021 Project, the "Project"); (3) pay a portion of the interest accruing on the Bonds (as defined below) for approximately 24 months; and (4) pay certain expenses incurred in connection with the authorization and issuance of the Bonds by the Commission; and

WHEREAS, the Commission has determined that the public will best be served by the proposed financing and, by a resolution adopted on May 14, 2021, has approved the issuance of the Bonds, subject to compliance by the Corporation with the conditions set forth in such resolution, and the Corporation has complied with such conditions to the satisfaction of the Commission; and

WHEREAS, there have been presented to officers and staff of the Commission draft copies of the following documents relating to the issuance of the Bonds:

(a) a Contract of Purchase relating to the Commission's Retirement Facilities First Mortgage Revenue and Refunding Revenue Bonds (Plantation Village, Inc.) Series 2021A (the "2021A Bonds"), dated November 18, 2021 (the "2021A Purchase Contract"), between the Local Government Commission of North Carolina (the "Local Government Commission") and Herbert J. Sims & Co., Inc. (the "Underwriter"), and approved by the Commission and the Corporation;

(b) a Trust Agreement, dated as of December 1, 2021 (the "2021A Trust Agreement"), between the Commission and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "2021A Bond Trustee"), relating to the 2021A Bonds;

(c) a Loan Agreement, dated as of December 1, 2021 (the "2021A Loan Agreement"), between the Commission and the Corporation, pursuant to which the Commission will lend the proceeds of the 2021A Bonds to the Corporation;

(d) the Master Trust Indenture, dated as of December 1, 2021 (the "Master Indenture"), between the Corporation and The Bank of New York Mellon Trust Company, N.A., as master trustee (the "Master Trustee");

(e) a Supplemental Master Indenture Number 1, dated as of December 1, 2021 ("Supplement No. 1"), by and between the Corporation and the Master Trustee;

(f) Obligation No. 1, dated as of the date of issuance of the 2021A Bonds ("Obligation No. 1"), to be issued by the Corporation to the Commission in connection with the 2021A Bonds;

(g) Obligation No. 2, dated as of the date of issuance of the 2021B Bonds ("Obligation No. 2, and together with Obligation No. 1, the "Bond Obligations"), to be issued by the Corporation to the Commission in connection with the 2021B Bonds (as defined below);

(h) a Preliminary Official Statement of the Commission dated November 3, 2021, as supplemented on November 15, 2021, relating to the 2021A Bonds (the "Preliminary Official Statement");

(i) a Contract of Purchase relating to the Commission's Retirement Facilities First Mortgage Revenue Bonds (Plantation Village, Inc.) Series 2021B (the "2021B Bonds," and together with the 2021A Bonds, the "Bonds"), dated December 2, 2021 (the "2021B Purchase Contract," and together with the 2021A Purchase Contract, the "Purchase Contracts"), between First-Citizens Bank & Trust Company (the "Purchaser") and the Local Government Commission and approved by the Commission and the Corporation;

(j) a Trust Agreement, dated as of December 1, 2021 (the "2021B Trust Agreement," and together with the 2021A Trust Agreement, the "Trust Agreements"), between the Commission and The Bank of New York Mellon Trust Company, N.A., as bond

trustee (the "2021B Bond Trustee," and together with the 2021A Bond Trustee, the "Bond Trustee"), relating to the 2021B Bonds;

(k) a Loan Agreement, dated as of December 1, 2021 (the "2021B Loan Agreement," and together with the 2021A Loan Agreement, the "Loan Agreements"), between the Commission and the Corporation, pursuant to which the Commission will lend the proceeds of the 2021B Bonds to the Corporation;

(l) a Supplemental Master Indenture Number 2, dated as of December 1, 2021 ("Supplement No. 2," and together with Supplement No. 1, the "Supplemental Indentures"), by and between the Corporation and the Master Trustee;

(m) a Continuing Covenants Agreement dated as of December 1, 2021 (the "Credit Agreement") between the Corporation and the Purchaser, relating to the 2021B Bonds;

(n) Obligation No. 3, dated as of the date of issuance of the 2021B Bonds ("Obligation No. 3," and together with the Bond Obligations, the "Obligations"), to be issued by the Corporation to the Purchaser;

(o) a Deed of Trust, Assignment of Rents, Security Agreement and Fixture Filing, dated as of December 1, 2021 (the "Deed of Trust") from the Corporation to the deed of trust trustee named therein for the benefit of the Master Trustee;

(p) a Construction Disbursement and Monitoring Agreement, dated as of December 1, 2021 (the "Disbursement Agreement"), among the Corporation, Alcala Construction Management, Inc., the Purchaser and the Bond Trustee; and

(q) an Assignment of Contracts dated as of December 1, 2021 (the "Assignment of Contracts"), made by the Corporation to the Master Trustee; and

WHEREAS, the Commission has determined that the Corporation is financially responsible and capable of fulfilling its obligations under the Loan Agreements, the Master Indenture, Supplement No. 1 and the Bond Obligations; and

WHEREAS, the Commission has determined that adequate provision has been made for the payment of the principal of, redemption premium, if any, and interest on the Bonds;

NOW, THEREFORE, THE NORTH CAROLINA MEDICAL CARE COMMISSION DOES HEREBY RESOLVE, as follows:

Section 1. Capitalized words and terms used in this Resolution and not defined herein shall have the same meanings in this Resolution as such words and terms are given in the Master Indenture, the Trust Agreements and the Loan Agreements.

Section 2. Pursuant to the authority granted to it by the Act, the Commission hereby authorizes the issuance of the 2021A Bonds in the aggregate principal amount of $32,740,000.

The 2021A Bonds shall mature in such amounts and at such times and bear interest at such rates as are set forth in Schedule 1 attached hereto.

The 2021A Bonds shall be issued as fully registered bonds in the denominations of $5,000 or any whole multiple thereof. The 2021A Bonds shall be issuable in book-entry form as provided in the 2021A Trust Agreement. Interest on the 2021A Bonds shall be paid on each January 1 and July 1, beginning July 1, 2022, to and including January 1, 2052. Payments of principal of and interest on the 2021A Bonds shall be forwarded by the 2021A Bond Trustee to the registered owners of the 2021A Bonds in such manner as is set forth in the 2021A Trust Agreement.

Section 3. Pursuant to the authority granted to it by the Act, the Commission hereby authorizes the issuance of 2021B Bonds in the aggregate principal amount of up to $31,916,000, which shall be issued as the 2021B-1 Bonds ($14,051,000) and the 2021B-2 Bonds ($17,865,000) solely for the purpose of having different maturity dates, interest rates and redemption requirements and being able to track the Qualifying Intermediate-Term Indebtedness (as defined in the Master Indenture) more easily. The 2021B-1 Bonds shall mature on December 1, 2036 and shall bear interest at a rate of 2.15% in accordance with the 2021B Trust Agreement. The 2021B-1 Bonds shall be subject to Sinking Fund Requirements set forth in Schedule 1 and Exhibit A hereto. The 2021B-2 Bonds shall mature on December 1, 2028 assuming certain conditions are met by the Corporation, but no earlier than December 1, 2026 in any event, and shall bear interest at a rate of 1.60% in accordance with the 2021B Trust Agreement. There are no Sinking Fund Requirements for the 2021B-2 Bonds, which are expected to be paid from initial entrance fees of the new independent living units of the 2021 Project.

The 2021B Bonds shall be issued as fully registered bonds in denominations of $100,000 or any multiple of $0.01 in excess thereof. Interest on the 2021B Bonds shall be paid on the first day of each calendar month, beginning January 1, 2022. Payments of principal of and interest on the 2021B Bonds shall be made to the registered owners of the 2021B Bonds in such manner as is set forth in the 2021B Trust Agreement.

Section 4. The Bonds shall be subject to optional, extraordinary and mandatory redemption, all at the times, upon the terms and conditions, and at the prices set forth in the Trust Agreements. The 2021B Bonds are also subject to certain prepayment premiums set forth in the Credit Agreement.

Section 5. The proceeds of the Bonds shall be applied as provided in Section 2.08 of each of the Trust Agreements. The Commission hereby finds that the use of the proceeds of the Bonds for loans to finance a portion of the costs of the 2021 Project, refinance the Prior Project, fund a portion of the interest on the Bonds, and pay certain costs of issuing the Bonds will accomplish the public purposes set forth in the Act.

Section 6. The forms, terms and provisions of the Trust Agreements and the Loan Agreements are hereby approved in all respects, and the Chairman or Vice Chairman (or any other member of the Commission designated by the Chairman) and the Secretary or any Assistant Secretary of the Commission are hereby authorized and directed to execute and deliver the Trust Agreements and the Loan Agreements in substantially the forms presented, together with such

changes, modifications and deletions as they, with the advice of counsel, may deem necessary and appropriate, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 7. The form, terms and provisions of the Purchase Contracts are hereby approved in all respects, and the Chairman, Vice Chairman (or any other member of the Commission designated by the Chairman), Secretary or any Assistant Secretary of the Commission and are hereby authorized and directed to execute and deliver the Purchase Contracts in substantially the forms presented, together with such changes, modifications, insertions and deletions as they, with the advice of counsel, may deem necessary and appropriate, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 8. The form of the Bonds of each series set forth in the applicable Trust Agreement is hereby approved in all respects, and the Chairman or Vice Chairman (or any other member of the Commission designated by the Chairman) and the Secretary or any Assistant Secretary of the Commission are hereby authorized and directed to execute, by manual or facsimile signature as provided in such form of the Bonds of such series, and to deliver to the applicable Bond Trustee for authentication on behalf of the Commission, the Bonds of such series in definitive form, which shall be in substantially the form presented, together with such changes, modifications and deletions as they, with the advice of counsel, may deem necessary, appropriate and consistent with the applicable Trust Agreement, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 9. The forms of the Master Indenture, the Supplemental Indentures, the Obligations, the Deed of Trust, the Assignment of Contracts, the Disbursement Agreement and the Credit Agreement are hereby approved in substantially the forms presented, together with such changes, modifications, insertions and deletions as the Chairman, Vice Chairman (or any other member of the Commission designated by the Chairman), Secretary or any Assistant Secretary of the Commission, with the advice of counsel, may deem necessary and appropriate, and the execution and delivery of the Trust Agreements by the Commission shall be conclusive evidence of the approval of the documents listed in this Section by the Commission.

Section 10. The Commission hereby approves the action of the Local Government Commission in awarding the 2021A Bonds to the Underwriter at the purchase price of $35,705,111.70 (representing the principal amount of the 2021A Bonds, plus original issue premium of $3,194,291.70 and less underwriter's discount of $229,180.00). The Commission hereby approves the action of the Local Government Commission authorizing the private sale of the 2021B Bonds to the Purchaser in accordance with the 2021B Contract of Purchase at the purchase price of 100% of the principal amount thereof.

Section 11. Upon their execution in the form and manner set forth in the applicable Trust Agreement, the Bonds of each series shall be deposited with the Bond Trustee for authentication, and the Bond Trustee is hereby authorized and directed to authenticate the Bonds of such series and, upon the satisfaction of the conditions set forth in Section 2.08 of the applicable Trust Agreement, the Bond Trustee shall deliver (1) the 2021A Bonds to the Underwriter and (2) the 2021B Bonds to the Purchaser, each against payment therefor.

Section 12. The Commission hereby approves and ratifies the use and distribution of the Preliminary Official Statement and approves the use and distribution of a final Official Statement (the "Official Statement"), both in connection with the offer and sale of the 2021A Bonds. The Chairman, Vice Chairman (or any other member of the Commission designated by the Chairman), Secretary and any Assistant Secretary are hereby authorized to execute, on behalf of the Commission, the Official Statement in substantially the form of the Preliminary Official Statement, together with such changes, modifications and deletions as they, with the advice of counsel, may deem appropriate. Such execution shall be conclusive evidence of the approval thereof by the Commission. The Commission hereby approves and authorizes the distribution and use of copies of the Official Statement, the Trust Agreements, the Loan Agreements, the Master Indenture, the Supplemental Indentures, the Obligations, the Deed of Trust, the Assignment of Contracts, the Disbursement Agreement and the Credit Agreement by the Underwriters in connection with such offer and sale.

Section 13. The Bank of New York Mellon Trust Company, N.A.is hereby appointed as the initial Bond Trustee for each series of Bonds.

Section 14. The Depository Trust Company, New York, New York is hereby appointed as the initial Securities Depository for the 2021A Bonds, with Cede & Co., a nominee thereof, being the initial Securities Depository Nominee and initial registered owner of the 2021A Bonds.

Section 15. S. Mark Payne, Secretary of the Commission, Geary W. Knapp, Assistant Secretary of the Commission, Anthony J. Harms, Acting Chief of the Construction Section of the Division of Health Service Regulation, and Kathy C. Larrison and Crystal Watson-Abbott, Auditors for the Commission, are each hereby appointed a Commission Representative as that term is defined in the Loan Agreements, with full power to carry out the duties set forth therein.

Section 16. The Chairman, Vice Chairman (or any other member of the Commission designated by the Chairman), Secretary and any Assistant Secretary of the Commission and are authorized and directed (without limitation except as may be expressly set forth herein) to take such action and to execute and deliver any such documents, certificates, undertakings, agreements or other instruments as they, with the advice of counsel, may deem necessary or appropriate to effect the transactions contemplated by the Trust Agreements, the Loan Agreements, the Purchase Contracts and the Official Statement.

Section 17. This Resolution shall take effect immediately upon its passage.

Schedule 1

Maturity Schedule for the 2021A Bonds

$8,130,000 4.0% Term Bonds due January 1, 2041

Due January 1	Sinking Fund Requirement
2037	$1,500,000
2038	1,560,000
2039	1,625,000
2040	1,690,000
2041*	1,755,000

* Maturity

$24,610,000 4.0% Term Bonds due January 1, 2052

Due January 1	Sinking Fund Requirement
2042	$1,825,000
2043	1,900,000
2044	1,975,000
2045	2,055,000
2046	2,135,000
2047	2,220,000
2048	2,310,000
2049	2,400,000
2050	2,495,000
2051	2,595,000
2052*	2,700,000

* Maturity

2021B Bonds

Principal payments on the 2021B-1 Bonds are required to be paid monthly beginning on January 1, 2026. Such payments are shown on **Exhibit A** attached hereto.

There are no mandatory redemption requirements for the 2021B-2 Bonds, which are expected to be paid from initial entrance fees of the new independent living units of the 2021 Project.

Professional Fees Comparison for
Plantation Village, Inc.
Series 2021A and Series 2021B

Professional	Fees Estimated In Preliminary Approval Resolution	Actual Fees
Underwriters' discount/placement fee	$606,340	$356,844.00
Accountants	30,000	42,000.00
Bond counsel	150,000	150,000.00
Corporation counsel	100,000	100,000.00
Feasibility consultant/study	150,000	105,000.00
Underwriters' counsel (2021A)	125,000	85,000.00
Bank (Purchaser) origination fee (2021B)	N/A	47,874.00
Bank (Purchaser) Counsel (2021B)	N/A	50,000.00

EXHIBIT A

Monthly Principal Payments for 2021B-1 Bonds

Maturity Date	Amount
1/1/2026	$95,000
2/1/2026	95,000
3/1/2026	95,000
4/1/2026	95,000
5/1/2026	95,000
6/1/2026	95,000
7/1/2026	96,000
8/1/2026	95,000
9/1/2026	95,000
10/1/2026	95,000
11/1/2026	95,000
12/1/2026	95,000
1/1/2027	95,000
2/1/2027	95,000
3/1/2027	100,000
4/1/2027	95,000
5/1/2027	95,000
6/1/2027	95,000
7/1/2027	98,000
8/1/2027	95,000
9/1/2027	95,000
10/1/2027	100,000
11/1/2027	100,000
12/1/2027	100,000
1/1/2028	100,000
2/1/2028	100,000
3/1/2028	100,000
4/1/2028	100,000
5/1/2028	100,000
6/1/2028	100,000
7/1/2028	100,000
8/1/2028	100,000
9/1/2028	100,000
10/1/2028	100,000
11/1/2028	100,000
12/1/2028	100,000

Maturity Date	Amount
1/1/2029	$100,000
2/1/2029	100,000
3/1/2029	105,000
4/1/2029	100,000
5/1/2029	100,000
6/1/2029	100,000
7/1/2029	102,000
8/1/2029	100,000
9/1/2029	100,000
10/1/2029	105,000
11/1/2029	100,000
12/1/2029	105,000
1/1/2030	105,000
2/1/2030	105,000
3/1/2030	105,000
4/1/2030	105,000
5/1/2030	105,000
6/1/2030	105,000
7/1/2030	104,000
8/1/2030	105,000
9/1/2030	105,000
10/1/2030	105,000
11/1/2030	105,000
12/1/2030	105,000
1/1/2031	105,000
2/1/2031	105,000
3/1/2031	105,000
4/1/2031	105,000
5/1/2031	105,000
6/1/2031	105,000
7/1/2031	107,000
8/1/2031	105,000
9/1/2031	105,000
10/1/2031	105,000
11/1/2031	105,000
12/1/2031	105,000
1/1/2032	105,000
2/1/2032	105,000
3/1/2032	110,000
4/1/2032	110,000
5/1/2032	110,000

Maturity Date	Amount
6/1/2032	$110,000
7/1/2032	109,000
8/1/2032	110,000
9/1/2032	110,000
10/1/2032	110,000
11/1/2032	110,000
12/1/2032	110,000
1/1/2033	110,000
2/1/2033	110,000
3/1/2033	110,000
4/1/2033	110,000
5/1/2033	110,000
6/1/2033	110,000
7/1/2033	111,000
8/1/2033	110,000
9/1/2033	110,000
10/1/2033	110,000
11/1/2033	110,000
12/1/2033	110,000
1/1/2034	110,000
2/1/2034	110,000
3/1/2034	115,000
4/1/2034	115,000
5/1/2034	115,000
6/1/2034	115,000
7/1/2034	114,000
8/1/2034	115,000
9/1/2034	115,000
10/1/2034	115,000
11/1/2034	115,000
12/1/2034	115,000
1/1/2035	115,000
2/1/2035	115,000
3/1/2035	115,000
4/1/2035	115,000
5/1/2035	115,000
6/1/2035	115,000
7/1/2035	116,000
8/1/2035	115,000
9/1/2035	115,000
10/1/2035	115,000

Maturity Date	Amount
11/1/2035	$115,000
12/1/2035	115,000
1/1/2036	115,000
2/1/2036	115,000
3/1/2036	120,000
4/1/2036	120,000
5/1/2036	120,000
6/1/2036	120,000
7/1/2036	119,000
8/1/2036	120,000
9/1/2036	120,000
10/1/2036	120,000
11/1/2036	120,000
12/1/2036	120,000
	$14,051,000

3. Adjournment

There being no further business, the meeting was adjourned at 11:50 a.m.

Respectfully submitted,

_____

Geary W. Knapp
Assistant Secretary

3. **Adjournment**

There being no further business, the meeting was adjourned at 11:50 a.m.

Respectfully submitted,

Geary W. Knapp
Assistant Secretary

NC MCC Bond Sale Approval Form
Facility Name: Plantation Village

	Time of Preliminary Approval	Time of Mailing POS (if applicable)	Time of Final Approval	Total Variance	Explanation of Variance
SERIES:					
PAR Amount	$87,618,535.00	$32,520,000.00	$32,740,000.00	($54,878,535.00)	Bank participated in deal.
Estimated Interest Rate	4.50%	4.00%	4.00%	-0.50%	Market permitted lower rates.
All-in True Interest Cost	4.44%	3.74%	3.50%	-0.94%	Market was better than estimated rates/yields.
Maturity Schedule (Interest) - Date	Semi-annual; 4/1 and 10/1	Semi-annual 1/1 and 7/1	Semi-annual 1/1 and 7/1		
Maturity Schedule (Principal) - Date	Annual 4/1; max 4/1/2051	Annual 1/1 for fixed rate bonds, commencing 1/1/2037 through 1/1/2052	Annual 1/1 for fixed rate bonds, commencing 1/1/2037 through 1/1/2052		
Bank Holding Period (if applicable) - Date	N/A	N/A	N/A		
Estimated NPV Savings ($) (if refunded bonds)	N/A	N/A	N/A		
Estimated NPV Savings (%) (if refunded bonds)	N/A	N/A	N/A		
NOTES:	For the application, we assumed all fixed rate bonds. We are soliciting bank interest for a portion of the par to be repaid with entrance fees with a maximum term of 7 years. The balance would be fixed rate bonds.				

	Time of Preliminary Approval	Time of Mailing POS (if applicable)	Time of Final Approval	Total Variance	Explanation of Variance
SERIES:					
PAR Amount		$17,865,000.00	$17,865,000.00		
Estimated Interest Rate		1.60%	1.60%		
All-in True Interest Cost		1.81%	1.85%		Slightly higher COI allocated to issuance
Maturity Schedule (Interest) - Date		Monthly	Monthly		
Maturity Schedule (Principal) - Date		Balloon 12/1/2026	Balloon 12/1/2026		
Bank Holding Period (if applicable) - Date		5 years	5 years		
Estimated NPV Savings ($) (if refunded bonds)		N/A	N/A		
Estimated NPV Savings (%) (if refunded bonds)		N/A	N/A		
NOTES:					

	Time of Preliminary Approval	Time of Mailing POS (if applicable)	Time of Final Approval	Total Variance	Explanation of Variance
SERIES:					
PAR Amount		$15,593,000.00	$14,051,000.00		Par adjusted to create level debt service
Estimated Interest Rate		2.15%	2.15%		
All-in True Interest Cost		2.11%	2.12%		
Maturity Schedule (Interest) - Date		Monthly	Monthly		
Maturity Schedule (Principal) - Date		Monthly, commencing 1/1/2026 until 12/1/2036	Monthly, commencing 1/1/2026 until 12/1/2036		
Bank Holding Period (if applicable) - Date		15 years	15 years		
Estimated NPV Savings ($) (if refunded bonds)		N/A	N/A		
Estimated NPV Savings (%) (if refunded bonds)		N/A	N/A		
NOTES:					

Compliance Summary:

- **No Violation of MCC Compliance policy**

1) Does Organization have a formal post tax issuance compliance policy?

   Yes

2) Who in the Organization will be designated to ensure appropriate compliance with the issuance?

   Chief Financial Officer

3) What is the Organization's compliance monitoring plan?

   The organization has a schedule of posting requirements, including timing, that is consistently reviewed to ensure on-going compliance.

4) How will the Organization report compliance deficiencies to leadership and the Board?

   Any deficiencies are cured as quickly as possible with notifications made to leadership and the Board, as appropriate.

Selected Application Information:

1) Information from FYE 2021 (9/30 Year End) Audit of Deerfield Episcopal Retirement Community, Inc.:

Net Income	$ 16,301,006
Operating Revenue	$ 50,621,253
Operating Expenses	($ 35,132,057)
Net Cash provided by Operating Activities	$ 9,446,986
Change in Net Assets	$ 13,906,147
Unrestricted Cash	$ 9,173,469
Change in Cash	($ 1,131,542)

***Cash Outflows included purchase of property, & equipment, payment of bond principal, and entrance fee refunds

2) Ratings:

Fitch: A with Outlook Stable

3) Community Benefits (FYE 2021):

Per N.C.G.S § 105 – 5.54% (Eligible for 100% property tax exclusion)

- Total Community Benefits and Charity Care - $1,968,000

4) Long-Term Debt Service Coverage Ratios:

Actual FYE 2021	2.64
Forecasted FYE 2022	3.15
Forecasted FYE 2023	2.67
Forecasted FYE 2024	2.81
Forecasted FYE 2025	3.43
Forecasted FYE 2026	4.37

5) Transaction Participants:

Bond Counsel:	Womble Bond Dickinson (US) LLP
Underwriter:	B.C. Ziegler and Company
Underwriter Counsel:	Robinson, Bradshaw, & Hinson, P.A.
Borrower Counsel:	McGuire Wood & Bissette
Accountant (AUP Forecast):	Clifton Larson Allen
Trustee:	TBD
Trustee Counsel:	TBD

6) Other Information:

(a) Board diversity

Male:	10
Female:	6
Total:	16

Caucasian:	14
Puerto Rican:	1
African American:	1
	16

(b) Diversity of residents (626 Residents)

Male:	237
Female:	389
Total:	626

Caucasian:	624
African American/Asian/Indian/Other:	2
Total:	626

****30 residents were born outside United States

(c) Fee Schedule – Attached (C-3)
(d) MCC Bond Sale Approval Policy Form – Attached (C-7)

DEERFIELD RATE SCHEDULE 2021-2022

SEE REVERSE SIDE FOR ADDITIONAL PRICING INFORMATION.

Residence Type	Residence Description	Sq. Ft.	No. of Persons	Standard Entrance Fee	50% Refund*	90% Refund*	Monthly Fee**
Cottage A	Two Bedroom, Two Car Garage	1,780	1 2	$491,279 $560,279	$653,402 $745,172	$908,867 $1,036,517	$4,396 $5,833
Cottage A	Two Bedroom with Den, Two Car Garage	2,044	1 2	$559,029 $628,029	$743,509 $835,279	$1,034,204 $1,161,854	$4,659 $6,096
Cottage B	Two Bedroom with Den, Two Car Garage	1,946	1 2	$533,561 $602,561	$709,636 $801,406	$987,087 $1,114,737	$4,477 $5,914
Cottage C	Two Bedroom with Den, Two Car Garage	1,943	1 2	$531,428 $600,428	$706,799 $798,569	$983,141 $1,110,791	$4,464 $5,901
Cottage D	Two Bedroom with Den, Two Car Garage	2,565	1 2	$680,532 $749,532	$905,108 $996,878	$1,258,985 $1,386,635	$5,136 $6,573
Villa I	Two Bedroom Duplex with Den, One-and-a-half Car Garage	1,592	1 2	$474,092 $543,092	$630,543 $722,313	$877,071 $1,004,721	$4,237 $5,674
Villa II	Two Bedroom Duplex with Den, One-and-a-half Car Garage	1,650	1 2	$481,635 $550,635	$640,575 $732,345	$891,026 $1,018,676	$4,295 $5,732
Villa III	Two Bedroom Duplex with Den, Two Car Garage	2,146	1 2	$570,740 $639,740	$759,084 $850,854	$1,055,868 $1,183,518	$4,813 $6,250
The Timbers A, B	Standard Two Bedroom Cluster Home with Deck	1,316	1	$341,386 $410,386	$454,044 $545,814	$631,565 $759,215	$3,202 $4,639
The Timbers D	Large Two Bedroom Cluster Home with Deck	1,487	1 2	$385,745 $454,745	$513,041 $604,811	$713,629 $841,279	$3,767 $5,204

The St. Giles cottages in a range of designs and square footage are individually priced. Future remarketing of all cottages will be priced individually as custom modification and square footage dictate. Underground parking in Tuton Hall and covered parking spaces in Henry and Timson Halls are available at an additional cost.

Future Residency Fee: $1,000, with $500 refundable upon cancellation.

***** Monthly fees are effective October 1, 2021.***

*** Prices subject to change.*

** Please check with your marketing associate about age requirements.*

Directions:

From Interstate 26:

1. Take Exit 37 and go east on Long Shoals Road to Hwy. 25 (Hendersonville Road).
2. Turn left (north) on Hwy. 25 and go approximately 2 miles.
3. Turn left into Deerfield at the stoplight.

From Interstate 40:

1. Take Exit 50, heading south on Hwy. 25 (Hendersonville Road).
2. Go approximately 3.5 miles on Hwy. 25, heading south.
3. Cross under Blue Ridge Parkway and turn right at the second stoplight into Deerfield.

Deerfield

1617 Hendersonville Road Asheville, NC 28803
800.284.1531 828.274.1531 fax 828.274.0238
www.deerfieldwnc.org

DEERFIELD RATE SCHEDULE 2021-2022

SEE REVERSE SIDE FOR ADDITIONAL PRICING INFORMATION.

Residence Type	Residence Description	Sq. Ft.	No. of Persons	Standard Entrance Fee	50% Refund*	90% Refund*	Monthly Fee**
Apartment A	One Bedroom	800	1 2	$223,837 $292,837	$297,703 $389,473	$414,099 $541,749	$3,018 $4,455
Apartment B	One Bedroom with Carolina Room	946	1 2	$255,139 $324,139	$339,335 $431,105	$472,007 $599,657	$3,202 $4,639
Apartment C	Two Bedroom	1,203	1 2	$329,480 $398,480	$438,209 $529,979	$609,539 $737,189	$3,673 $5,110
Apartment C-1	Two Bedroom Corner	1,440	1 2	$378,600 $447,600	$503,537 $595,307	$700,409 $828,059	$3,860 $5,297
Apartment D	Two Bedroom with Carolina Room	1,346	1 2	$363,739 $432,739	$483,773 $575,543	$672,917 $800,567	$3,767 $5,204
Apartment E	Two Bedroom Corner with Den	1,456	1 2	$393,270 $462,270	$523,049 $614,819	$727,549 $855,199	$3,902 $5,339
Apartment F	Two Bedroom Deluxe Corner with Den	1,552	1 2	$419,498 $488,498	$557,932 $649,702	$776,070 $903,720	$4,070 $5,507
Apartment G	Two Bedroom Grande Corner with Den	1,612	1 2	$435,135 $504,135	$578,729 $670,499	$805,000 $932,650	$4,168 $5,605
Apartment L	Two Bedroom Deluxe with Carolina Room	2,314	1 2	$602,048 $671,048	$800,723 $892,493	$1,113,788 $1,241,438	$4,818 $6,255

The Monthly Fee entitles Deerfield residents to enjoy the following services, programs, and amenities:

- One meal per day in your choice of dining venues
- Special diets and to-go meals
- All utilities, except telephone, cable television and internet
- 24-hour security staff and systems
- Weekly housekeeping
- Indoor and outdoor maintenance
- Groundskeeping
- Lighted parking
- Planned social, spiritual, recreational, educational, and cultural activities
- Scheduled transportation for local medical appointments and shopping
- Chaplain services and pastoral care
- Arts programs and activities
- Aquatic programs
- Exercise and wellness programs with personal trainers
- Additional storage space
- On-site health center with Assisted Living and Skilled Nursing accommodations
- 24-hour emergency assistance
- Routine clinic services
- Fun, freedom, and peace of mind

***** Monthly fees are effective October 1, 2021.***
***** Prices subject to change.***
**** Please check with your marketing associate about age requirements.***

Deerfield

1617 Hendersonville Road Asheville, NC 28803
800.284.1531 828.274.1531 fax 828.274.0238
www.deerfieldwnc.org

Health Care Services Rate Schedule

Effective October 1, 2021

Simonds Skilled Nursing

Private Room with Shared Bath	$267 per day
Private Room with Private Bath	$327 per day
Private Room with Private Bath (Large)	$345 per day
Direct Admission Fee	$10,000 per resident

Haden Hall Assisted Living

Standard Assisted Living Suite	$5,152 per month
Deluxe Assisted Living Suite	$6,592 per month
Grande Assisted Living Suite	$7,064 per month
2nd Person Fee	$4,206 per month
Direct Admission Fee	$30,000 per resident

Rates may be subject to change.

Deerfield Waitlist as of 09/30/21 was 1,315

Deerfield

1617 Hendersonville Road Asheville, NC 28803
800.284.1531 828.274.1531 fax 828.274.0238
www.deerfieldwnc.org

Expansion Price Ranges

The planned 90-unit apartment building is five stories and includes one underbuilding parking space for each unit. It is attached to current buildings and amenities by a fully conditioned corridor. All apartments are new open-concept designs. A variety of the apartments include a premium added to the entrance fee for new water feature views.

One Bedroom Apartments: (this pricing does not include second person fees)
Standard Entrance Fees $382,000 - $473,000
Monthly fees effective through September 30, 2022 $3,342 - $3,872

B2 977s.f. One Bedroom/One Bath plus Den

I 1,051s.f. One Bedroom /One Bath

H 1,233s.f. One Bedroom/One and a half Bath

Two Bedroom Apartments: (this pricing does not include second person fees)
Standard Entrance Fees $486,000 - $716,000
Monthly fees effective through September 30, 2022 $3,866 - $4,884

C2 1,275s.f. Two Bedroom/Two Bath

D2 1,408s.f. Two Bedroom/Two Bath

E2 1,478s.f. Two Bedroom/Two Bath plus Den

F 1,830s.f. Two Bedroom/Two and a half Bath plus Den

F2 1,610s.f. Two Bedroom/Two Bath

G2 1,934s.f. Two Bedroom/Two and a half Bath plus Den

The planned Canterbury Homes (Hybrids) are 12-unit buildings with three stories and include one underbuilding parking space for each unit. All apartments are corner apartments with new open-concept designs. Some of the apartments include a premium added to the entrance fee for new water feature views.

Canterbury Homes: (this pricing does not include second person fees)
Standard Entrance Fees $632,000 - $727,000
Monthly fees effective through September 30, 2022 $4,308 - $4,791

A 1,573s.f. Two Bedroom/Two and a half Bath

A1 1,712s.f. Two Bedroom/Two and a half Bath plus Den

B 1,762s.f. Two Bedroom/Two Bath plus Den

C 1,771s.f. Two Bedroom/Two and a half Bath

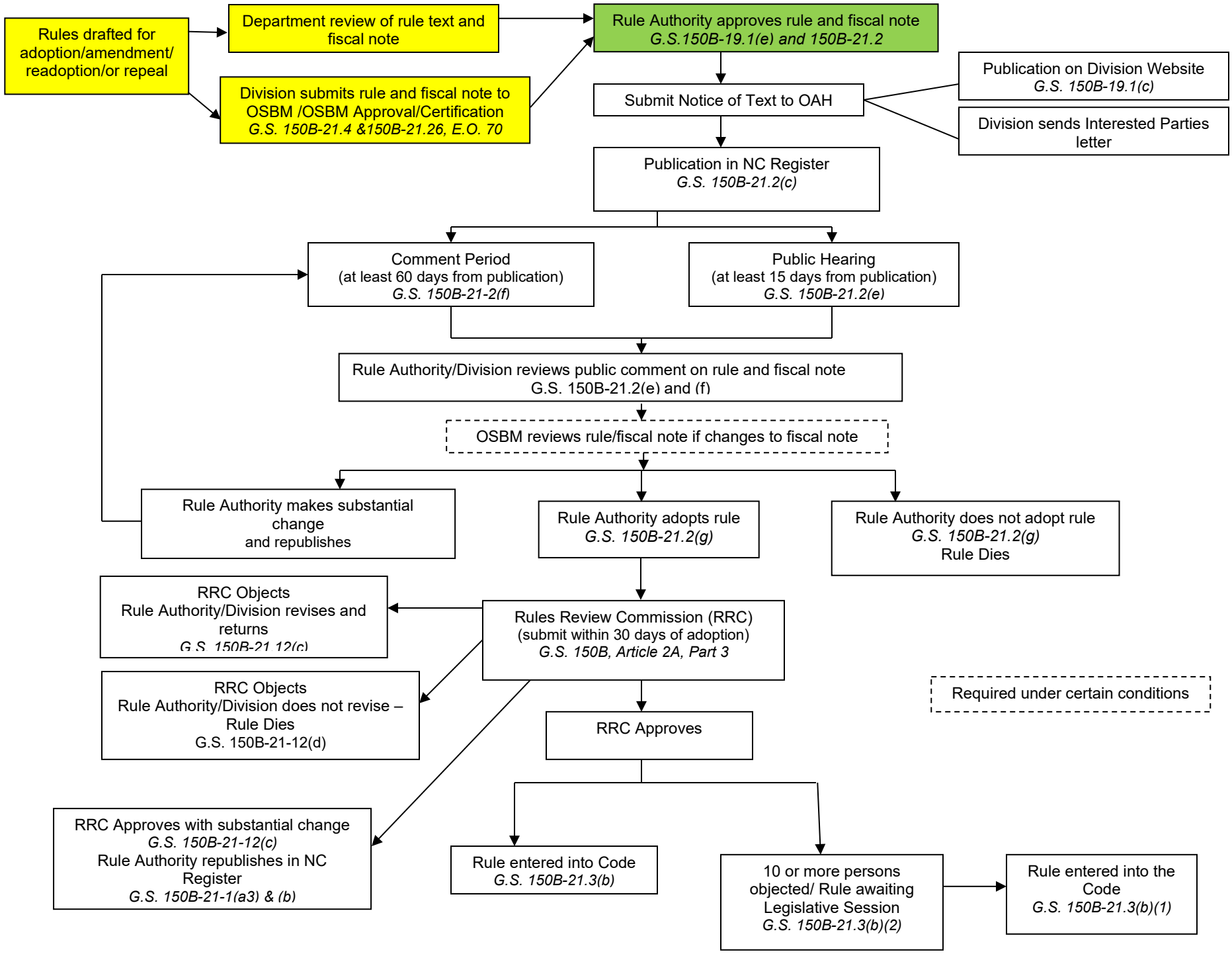
C1 1,898s.f. Two Bedroom/Two and a half Bath plus Den

D 1,873s.f. Two Bedroom/Two and a half Bath plus Den

NC MCC Bond Sale Approval Form	
Facility Name:	**Deerfield Episcopal Retirement Community**
	Time of Preliminary Approval
SERIES:	**2022A**
PAR Amount	$158,820,000.00
Estimated Interest Rate	5.00%
All-in True Interest Cost	5.10%
Maturity Schedule (Interest) - Date	Semi-Annual May 1 and Nov. 1
Maturity Schedule (Principal) - Date	Annual Nov. 1 Beginning 2026
Bank Holding Period (if applicable) - Date	NA
Estimated NPV Savings ($) (if refunded bonds)	NA
Estimated NPV Savings (%) (if refunded bonds)	NA
NOTES:	
	Time of Preliminary Approval
SERIES:	**2022B**
PAR Amount	$63,045,000.00
Estimated Interest Rate	3.00% (Variable)
All-in True Interest Cost	3.43%
Maturity Schedule (Interest) - Date	Monthly on 1st Day of Month
Maturity Schedule (Principal) - Date	As Entry Fees are Received
Bank Holding Period (if applicable) - Date	5-7 Years (Estimated)
Estimated NPV Savings ($) (if refunded bonds)	NA
Estimated NPV Savings (%) (if refunded bonds)	NA
NOTES:	Component to be paid with initial entrance fees from new ILUs.
	Bank solicitation process will be run in the coming months to fine tune the specifics of the bank loan.

Process for Medical Care Commission to Initiate Rulemaking

Exhibit D



10A NCAC 13F .0404 is proposed for readoption with substantive changes as follows:

10A NCAC 13F .0404 QUALIFICATIONS OF ACTIVITY DIRECTOR

~~There shall be a designated adult~~ Adult care ~~home~~ homes shall have an activity director who meets the following qualifications:

(1) The activity director ~~(employed~~ hired on or after ~~August 1, 1991)~~ September 30, 2022 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.~~ Program.

(2) The activity director hired on or after ~~July 1, 2005~~ September 30, 2022 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.~~ An activity director shall be exempt from the required basic activity course if one or more of the following applies:

(a) be a licensed recreational therapist or be eligible for certification as a therapeutic recreation specialist as defined by the North Carolina Recreational Therapy Licensure Act in accordance with G.S. 90C;

(b) have two years of experience working in a social or recreation program within the last five years, one year of which was full-time in a patient activities program in a health care setting;

(c) be a licensed occupational therapist or licensed occupational therapy assistant in accordance with G.S. 90, Article 18D; or

(d) be certified as an Activity Director by the National Certification Council for Activity Professionals.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1987; April 1, 1984;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, ~~2005.~~ 2005;

Readopted Eff. October 1, 2022.

10A NCAC 13F .0407 is proposed for readoption with substantive changes as follows:

10A NCAC 13F .0407 OTHER STAFF QUALIFICATIONS

(a) Each staff person at an adult care home shall:

(1) have a job description that reflects ~~actual~~ the positions, duties and responsibilities and is signed by the administrator and the employee;

(2) be able to ~~apply~~ implement all of the adult care home's accident, fire ~~safety~~ 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~~ the information from unauthorized use and ~~disclosure.~~ disclosure, in accordance with ~~Note: G.S. 131D-2(b)(4), 131D-21(6),~~ 131D-21(6) and ~~131D-21.1 govern the disclosure of such information;~~ 131D 21.1;

(4) not hinder or interfere with the exercise of the rights guaranteed under the Declaration of Residents' Rights in G.S. 131D-21;

(5) have no 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~~ 131D-40;

(8) have results of the examination and screening for the presence of controlled substances in accordance with G.S. 131D-45;

~~(8)~~ (9) maintain a ~~valid~~ current driver's license if responsible for transportation of residents; and

~~(9)~~ (10) be willing to ~~work~~ cooperate with ~~bona fide~~ state and local inspectors ~~and the monitoring and licensing agencies toward meeting and maintaining~~ when determining and maintaining compliance with the rules of this Subchapter.

(b) ~~Any~~ At all times, there shall be at least one staff ~~member left~~ person in the facility ~~left~~ in charge of ~~the~~ resident care ~~of residents~~ who shall be 18 years or older.

(c) If licensed practical nurses are employed by the facility and practicing in their licensed capacity as governed by ~~their practice act and occupational licensing laws,~~ the North Carolina Board of Nursing, there shall be ~~continuous availability of~~ a registered nurse ~~consistent~~ available in accordance with the Rules set forth in ~~Rules~~ 21 NCAC 36 ~~.0224(i)~~ .0224 and 21 NCAC 36 ~~.0225.~~ .0225, which are hereby incorporated by reference including subsequent amendments.

~~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~~ 131D 4.5(4); 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;

Amended Eff. April 1, 1984;

Temporary Amendment Eff. September 1, 2003; July 1, 2003.

Amended Eff. June 1, ~~2004.~~ 2004;

Readopted Eff. October 1, 2022.

10A NCAC 13F .0501 is proposed for readoption with substantive changes as follows:

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

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

(a) ~~An adult care home~~ The facility shall assure that staff who provide or directly supervise staff who provide personal care to residents ~~successfully~~ complete an 80-hour personal care training and competency evaluation program established or approved by the Department. For the purpose of this Rule, ~~Directly supervise~~ "Directly supervise" means being on duty in the facility to oversee or direct the performance of staff duties. ~~Copies~~ A copy of the 80-hour training and competency evaluation program ~~are~~ is available ~~at the cost of printing and mailing by contacting the Division of Health Service Regulation, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708.~~ online at https://info.ncdhhs.gov/dhsr/acls/training/PCA-trainingmanual.html, at no cost. The 80-hour personal care training and competency evaluation program curriculum shall include:

(1) observation and documentation skills;

(2) basic nursing skills, including special health-related tasks;

(3) activities of daily living and personal care skills;

(4) cognitive, behavioral, and social care;

(5) basic restorative services; and

(6) residents' rights as established by G.S. 131D-21.

(b) The facility shall assure that training specified in Paragraph (a) of this Rule is ~~successfully~~ completed within six months after hiring for staff hired after ~~September 1, 2003.~~ October 1, 2022. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for ~~review.~~ review by the Division of Health Service Regulation and the county department of social services.

(c) The facility shall assure that staff who perform or directly supervise staff who perform personal care receive training and supervision on the performance of individual job assignments prior to meeting the training and competency requirements of this Rule. Documentation of training shall be maintained in the facility and available for review by the Division of Health Service Regulation and the county department of social services.

~~(c)~~ (d) The Department shall exempt staff from the 80-hour training and competency evaluation program who are:

(1) licensed health professionals;

(2) listed on the Nurse Aide Registry; or

(3) documented as having ~~successfully~~ completed ~~a 40-45 or 75-80 hour training program or competency evaluation program approved by the Department since January 1, 1996 according to Rule .0502 of this Section.~~ one of the following previously approved training programs:

(A) a 40-hour or 75-hour training and competency evaluation program prior to July 1, 2000; or

(B) a 45-hour or 80-hour training and competency evaluation program for training exemption from July 1, 2000 through August 31, 2003.

~~(d) The facility shall assure that staff who perform or directly supervise staff who perform personal care 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. Documentation of the on-the-job training shall be maintained in the facility and available for review.~~

History Note: *Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 143B-165;*
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, ~~2004.~~ 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13F .0502 is proposed for repeal as follows:

10A NCAC 13F .0502 PERSONAL CARE TRAINING CONTENT AND INSTRUCTORS

History Note: *Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 143B-165;*
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018. 2018;
Repealed Eff. October 1, 2022.

10A NCAC 13F .0503 is proposed for readoption without substantive changes as follows:

10A NCAC 13F .0503 MEDICATION ADMINISTRATION COMPETENCY

(a) The competency evaluation for medication administration required in Rule .0403 of this Subchapter shall consist of a written examination and a clinical skills evaluation to determine competency in the following areas:

(1) medical abbreviations and terminology;

(2) transcription of medication orders;

(3) obtaining and documenting vital signs;

(4) procedures and tasks involved with the preparation and administration of oral (including liquid, sublingual and inhaler), topical (including transdermal), ophthalmic, otic, and nasal medications;

(5) infection control procedures;

(6) documentation of medication administration;

(7) monitoring for reactions to medications and procedures to follow when there appears to be a change in the resident's condition or health status based on those reactions;

(8) medication storage and disposition;

(9) ~~regulations~~ rules pertaining to medication administration in adult care facilities; and

(10) the facility's medication administration policy and procedures.

(b) An individual shall score at least 90% on the written examination which shall be a standardized examination established by the Department.

(c) A certificate of successful completion of the written examination shall be issued to each participant ~~successfully completing the examination.~~ who successfully completes the examination as required in Paragraph (b) of this rule. 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~~ licensed 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 listed in Subparagraphs (a)(4), (a)(7), (a)(11), (a)(14), and (a)(15) as specified in Rule .0903 of this Subchapter.

(e) The Medication Administration Skills Validation Form shall be used to document successful completion of the clinical skills validation portion of the competency evaluation for those medication administration tasks to be performed in the facility employing the medication aide. The form requires the following:

(1) name of the staff and adult care home;

(2) satisfactory completion date of demonstrated competency of task or skill with the instructor's initials or signature;

(3) if staff needs more training on skills or tasks, it should be noted with the instructor's signature; and

(4) staff and instructor signatures and date after completion of tasks.

Copies of this form and instructions for its use may be obtained at no cost ~~by contacting the Adult Care Licensure Section, Division of Health Service Regulation, 2708 Mail Service Center, Raleigh, NC 27699-2708.~~ on the Adult Care Licensure website, https://info.ncdhhs.gov/dhsr/acls/pdf/medchklst.pdf. The completed form shall be maintained and available for review in the facility and is not transferable from one facility to another.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. January 1, 2000; December 1, 1999;
Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, ~~2004.~~ 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13F .0504 is proposed for amendment as follows:

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

(a) ~~An adult care home~~ The facility shall assure that ~~non-licensed personnel and licensed personnel~~ non-licensed staff and licensed staff not practicing in their licensed capacity ~~as governed by their practice act and~~ in accordance with 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~~ Subchapter. The facility shall assure the competency validation occurs 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 any of the personal care tasks specified in Subparagraphs (a)(1) through (28) of Rule .0903 of this Subchapter.

(2) In lieu of a registered nurse, a licensed 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), (a)(11), (a)(16), (a)(18), ~~(a)(19)~~ (a)(19), and (a)(21) of Rule .0903 of this Subchapter.

(3) In lieu of a registered nurse, a ~~registered~~ licensed pharmacist may validate the competency of staff who perform the personal care ~~task~~ tasks specified in Subparagraph (a)(8) and (a)(11) of Rule .0903 of this Subchapter. An immunizing pharmacist may validate the competency of staff who perform the personal care task specified in Subparagraph (a)(15) of Rule .0903 of this Subchapter.

(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-2.2(a) 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.~~ relocation of the resident.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. September 1, 2003;
Eff. July 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;
Amended Eff. October 1, 2022; July 1, 2021.

10A NCAC 13F .0508 is proposed for amendment as follows:

10A NCAC 13F .0508 ASSESSMENT TRAINING

The person or persons designated by the administrator to perform resident assessments as required by Rule .0801 of this Subchapter shall ~~successfully~~ complete training on resident assessment established by the Department before performing the required assessments. Registered nurses are exempt from the assessment training. The Resident Assessment Self-Instructional Manual for Adult Care Homes herein incorporated by reference including subsequent amendments and editions. The instruction manual on resident assessment is available on the ~~internet~~ Adult Care Licensure 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.~~ https://info.ncdhhs.gov/dhsr/acls/pdf/assessmentmanual.pdf, at no cost.

History Note: *Authority G.S. 131D-2.15; 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. September 1, 2003;
Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~2018.~~ 2018;
Amended Eff. October 1, 2022.

10A NCAC 13F .0905 is proposed for amendment as follows:

10A NCAC 13F .0905 ACTIVITIES PROGRAM

(a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community.

(b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities.

(c) The activity director, 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~~ 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,~~ to residents within the community, posted in a ~~prominent~~ location accessible to residents by the first day of each month, and updated when there are any changes;

(3) involve community resources, such as recreational, volunteer, ~~religious, aging and developmentally disabled associated agencies,~~ and religious organizations, to enhance the activities available to residents;

(4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program;

(5) encourage residents to participate in activities; and

(6) assure there are ~~adequate supplies~~, supplies necessary for planned activities, ~~supervision~~ 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~~ 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~~ Residents shall have the opportunity to participate in ~~meaningful work type and~~ volunteer service activities in the ~~home~~ facility or in the ~~community, but participation shall be on an entirely voluntary basis, never forced upon residents and not assigned in place of staff.~~ community. Participation in volunteer activities shall not be required of residents and shall not involve duties that are typically performed by facility staff.

History Note: *Authority G.S. 131D-2.16; ~~131D-4.5; 143B-165;~~ 131D-4.1; 131D-4.3;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1987; April 1, 1984;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. July 1, 2004;
Temporary Amendment Eff. July 1, 2004 (This temporary amendment replaces the permanent rule approved by RRC on May 20, 2004);
Amended Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~2018.~~ 2018;
Amended Eff. October 1, 2022.

10A NCAC 13F .1006 is proposed for readoption without substantive changes as follows:

10A NCAC 13F .1006 MEDICATION STORAGE

(a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified ~~in~~ by the adult care home's medication storage policy and procedures.

(b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained 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,~~ routinely cleaned, include functional lighting, ventilated to circulate fresh air, large enough to store medications in an orderly manner, and located in areas other than the bathroom, kitchen or utility room. Medication carts shall be ~~clean~~ routinely cleaned and medications shall be stored in an orderly manner.

(d) ~~Accessibility to locked~~ Locked storage areas for medications shall only be accessible by staff responsible for medication administration and administrator or ~~person in charge.~~ administrator-in-charge.

(e) Medications intended for topical or external use, except for ophthalmic, ~~otic~~ otic, and transdermal medications shall be stored in a designated area separate from the medications intended for oral and injectable use. Ophthalmic, ~~otic~~ otic, and transdermal medications may be stored with medications intended for oral and injectable use. Medications shall be stored apart from cleaning agents and hazardous chemicals.

(f) Medications requiring refrigeration shall be stored at 36 degrees F to 46 degrees F (2 degrees C to 8 degrees C).

(g) Medications shall not be stored in a refrigerator containing non-medications and non-medication related items, except when stored in a separate container. The container shall be locked when storing medications unless the refrigerator is locked or is located in a locked medication area.

(h) The facility may possess a stock of non-prescription medications or the following prescription legend medications for general or common ~~use:~~ use in accordance with physicians' orders:

(1) irrigation solutions in single unit quantities exceeding 49 ml. and related diagnostic agents;

(2) diagnostic agents;

(3) vaccines; and

(4) water for injection and normal saline for injection.

~~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,~~ available to staff within the facility, stored out of sight of residents and ~~visitors~~ visitors, and stored separately from medications, and in ~~a secure and~~ an orderly manner.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. October 1, 2022.

10A NCAC 13F .1008 is proposed for readoption without substantive changes as follows:

10A NCAC 13F .1008 CONTROLLED SUBSTANCES

(a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, ~~administration~~ 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~~ 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~~ 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~~ 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~~ destruction, and the initials or signature of the person destroying the substance.

(h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement ~~agency~~ agency, and Health Care Personnel Registry as required by ~~state~~ State law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. October 1, 2022.

10A NCAC 13F .1010 is proposed for readoption without substantive changes as follows:

10A NCAC 13F .1010 PHARMACEUTICAL SERVICES

(a) An adult care home shall allow the residents the right to choose a pharmacy provider as long as the pharmacy provides services that are in accordance with requirements of this Section and all applicable ~~state~~ State and federal rules and regulations and the facility's medication management policies and procedures.

(b) There shall be a current, written agreement with a licensed pharmacist or a prescribing practitioner for pharmaceutical care services in accordance with Rule .1009 of this Section. The written agreement shall include a statement of the responsibility of each party.

(c) The facility shall assure the provision of pharmaceutical services to meet the needs of the residents including procedures that assure the accurate ordering, ~~receiving~~ 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~~ 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:~~ include:

(A) the name and strength of the medication;

(B) the directions for administration as prescribed by the resident's physician; and

(C) any cautionary information from the original prescription package if the information is not on the container released for the leave of absence;

(3) ~~The~~ the resident's medication shall be provided in a capped or closed container that will protect the medications from contamination and spillage; and

(4) ~~Labeling~~ labeling of each of the resident's individual medication containers for the leave of absence shall be legible, include at least the name of the resident and the name and strength of the medication, and be affixed to each container.

The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation

of the quantities of medications released from and returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications' release from and return to the facility.

(e) The facility shall assure that accurate records of the receipt, use, and disposition of medications are maintained in the facility and available upon request for review.

(f) A facility with 12 or more beds shall have a current, written agreement with a pharmacy provider for dispensing services. The written agreement shall include a statement of the responsibility of each party.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. July 1, 2005;
Amended Eff. April 1, ~~2015.~~ 2015;
Readopted Eff. October 1, 2022.

10A NCAC 13F .1207 is proposed for amendment as follows:

10A NCAC 13F .1207 FACILTIES TO REPORT RESIDENT DEATHS

~~For purposes of this Section, facilities licensed in accordance with G.S. 131D-2~~ The facility shall report resident deaths to the Division of Health Service ~~Regulation.~~ Regulation in accordance with G.S. 131D-34.1.

History Note: *Authority G.S. 131D-2.4; 131D-2.16; ~~131D-2.4;~~ 131D-34.1;143B-165;*
Temporary Adoption Eff. May 1, 2001;
Eff. July 18, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~2018.~~ 2018;
Amended Eff. October 1, 2022.

10A NCAC 13G .0404 is proposed for readoption with substantive changes as follows:

10A NCAC 13G .0404 QUALIFICATIONS OF ACTIVITY DIRECTOR

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

(1) The activity director ~~(employed~~ hired on or after ~~August 1, 1991)~~ September 30, 2022 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.~~ Program.

(2) The activity director hired on or after ~~July 1, 2005~~ September 30, 2022 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 Professional 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.~~ An activity director shall be exempt from the required basic activity course if one or more of the following applies:

(a) be a licensed recreational therapist or be eligible for certification as a therapeutic recreation specialist as defined by the North Carolina Recreational Therapy Licensure Act in accordance with G.S. 90C;

(b) have two years of experience working in a social or recreation program within the last five years, one year of which was full-time in a patient activities program in a health care setting;

(c) be a licensed occupational therapist or licensed occupational therapy assistant in accordance with G.S. 90, Article 18D; or

(d) be certified as an Activity Director by the National Certification Council for Activity Professionals.

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.~~ 2005;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0406 is proposed for readoption with substantive changes as follows:

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~~ the positions, ~~duties~~ duties, and responsibilities and is signed by the administrator and the employee;

(2) be able to ~~apply~~ implement all of the family care home's accident, fire ~~safety~~ 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~~ the information from unauthorized use and ~~disclosure;~~ disclosure, in accordance with ~~Note: G.S. 131D-2(b)(4),~~ G.S. 131D-21(6), and ~~G.S. 131D-21.1 govern the disclosure of such the information;~~ G.S. 131D 21.1;

(4) not hinder or interfere with the exercise of the rights guaranteed under the Declaration of Residents' Rights in G.S. 131D-21;

(5) have no 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) have results of the examination and screening for the presence of controlled substances in accordance with G.S. 131D-45;

~~(8)~~ (9) maintain a ~~valid~~ current driver's license if responsible for transportation of residents; and

~~(9)~~ (10) be willing to ~~work~~ cooperate with ~~bona fide~~ state and local inspectors ~~and the monitoring and licensing agencies toward meeting and maintaining~~ when determining and maintaining compliance with the rules of this Subchapter.

(b) ~~Any~~ At all times, there shall be at least one staff ~~member~~ person in the facility ~~left~~ in charge of ~~the~~ resident care ~~of residents~~ who shall be 18 years or older.

(c) If licensed practical nurses are employed by the facility and practicing in their licensed capacity as governed by ~~their practice act and occupational licensing laws,~~ the North Carolina Board of Nursing, there shall be ~~continuous availability of~~ a registered nurse ~~consistent~~ available in accordance with the Rules set forth in ~~Rules~~ 21 NCAC 36 ~~.0224(i)~~ .0224 and 21 NCAC 36 ~~.0225.~~ .0225, which are hereby incorporated by reference including subsequent amendments.

~~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.~~ 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0501 is proposed for readoption with substantive changes as follows:

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.~~

(a) The facility shall assure that staff who provide or directly supervise staff who provide personal care to residents complete an 80-hour personal care training and competency evaluation program established by the Department. For the purpose of this Rule, "Directly supervise" means being on duty in the facility to oversee or direct the performance of staff duties. A copy of the 80-hour training and competency evaluation program is available online at https://info.ncdhhs.gov/dhsr/acls/training/PCA-trainingmanual.html, at no cost. The 80-hour personal care training and competency evaluation program curriculum shall include:

(1) observation and documentation skills;

(2) basic nursing skills, including special health-related tasks;

(3) activities of daily living and personal care skills;

(4) cognitive, behavioral, and social care;

(5) basic restorative services; and

(6) residents' rights as established by G.S. 131D-21.

(b) The facility shall assure that training specified in Paragraph (a) of this Rule is completed within six months after hiring for staff hired after October 1, 2022. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review by the Division of Health Service Regulation and the county department of social services.

(c) The facility shall assure that staff who perform or directly supervise staff who perform personal care receive training and supervision for the performance of individual job assignments prior to meeting the training and competency requirements of this Rule. Documentation of training shall be maintained in the facility and available for review by the Division of Health Service Regulation and the county department of social services.

(d) The Department shall exempt staff from the 80-hour training and competency evaluation program who are:

(1) licensed health professionals;

(2) listed on the Nurse Aide Registry; or

(3) documented as having completed one of the following previously approved training programs:

(A) a 20-hour or 75-hour training and competency evaluation program prior to July 1, 2000; or

(B) a 25-hour or 80-hour training and competency evaluation program from July 1, 2000 through September 30, 2017.

History Note: *Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 143B-165;*
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, ~~2000.~~ 2000;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0502 is proposed for readoption as a repeal as follows:

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

History Note: *Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 143B-165;*
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, ~~2000.~~ 2000;
Repealed Eff. October 1, 2022.

10A NCAC 13G .0503 is proposed for readoption without substantive changes as follows:

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:

(1) medical abbreviations and terminology;

(2) transcription of medication orders;

(3) obtaining and documenting vital signs;

(4) procedures and tasks involved with the preparation and administration of oral (including liquid, sublingual and inhaler), topical (including transdermal), ophthalmic, otic, and nasal medications;

(5) infection control procedures;

(6) documentation of medication administration;

(7) monitoring for reactions to medications and procedures to follow when there appears to be a change in the resident's condition or health status based on those reactions;

(8) medication storage and disposition;

(9) ~~regulations~~ rules pertaining to medication administration in adult care facilities; and

(10) the facility's medication administration policy and procedures.

(b) An individual shall score at least 90% on the written examination which shall be a standardized examination established by the Department.

(c) A certificate of successful completion of the written examination shall be issued to each participant ~~successfully completing the examination.~~ who successfully completes the examination as required in Paragraph (b) of this Rule. 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~~ licensed 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 listed in Subparagraphs (a)(4), (a)(7), (a)(11), (a)(14), and (a)(15) as specified in Rule .0903 of this Subchapter.

(e) The Medication Administration Skills Validation Form shall be used to document successful completion of the clinical skills validation portion of the competency evaluation for those medication administration tasks to be performed in the facility employing the medication aide. The form requires the following:

(1) name of the staff and adult care home;

(2) satisfactory completion date of demonstrated competency of task or skill with the instructor's initials or signature;

(3) if staff needs more training on skills or tasks, it should be noted with the instructor's signature; and

(4) staff and instructor signatures and date after completion of tasks.

Copies of this form and instructions for its use may be obtained at no cost ~~by contacting the Adult Care Licensure Section, Division of Health Service Regulation, 2708 Mail Service Center, Raleigh, NC 27699-2708~~. on the Adult Care Licensure website, https://info.ncdhhs.gov/dhsr/acls/pdf/medchklst.pdf. The completed form shall be maintained and available for review in the facility and is not transferable from one facility to another.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. January 1, 2000; December 1, 1999;
Eff. July 1, ~~2000.~~ 2000;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0504 is proposed for readoption with substantive changes as follows:

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

(a) ~~A family care home~~ The facility shall assure that ~~non-licensed personnel and licensed personnel~~ non-licensed staff and licensed staff not practicing in their licensed capacity ~~as governed by their practice act and~~ in accordance with 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~~ Subchapter. The facility shall assure the competency validation occurs 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 any of the personal care tasks specified in Subparagraphs (a)(1) through (28) of Rule .0903 of this Subchapter.

(2) In lieu of a registered nurse, a licensed 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)~~ (19), and (21) of Rule .0903 of this Subchapter.

(3) In lieu of a registered nurse, a ~~registered~~ licensed pharmacist may validate the competency of staff who perform the personal care ~~task~~ tasks specified in Subparagraph (a)(8) and (11) of Rule .0903 of this Subchapter. An immunizing pharmacist may validate the competency of staff who perform the personal care task specified in Subparagraph (a)(15) of Rule .0903 of this Subchapter.

(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)~~ 131D-2.2(a) 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.~~ relocation of the resident.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. September 1, 2003;
Eff. July 1, ~~2004.~~ 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0507 is proposed for readoption with substantive changes as follows:

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.~~ The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. September 1, 2003;
Eff. July 1, ~~2004.~~ 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0508 is proposed for readoption without substantive changes as follows:

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 Resident Assessment Self-Instructional Manual for Adult Care Homes herein incorporated by reference including subsequent amendments and editions. The instruction manual on resident assessment is available on the ~~internet~~ Adult Care Licensure 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.~~ https://info.ncdhhs.gov/dhsr/acls/pdf/assessmentmanual.pdf, at no cost.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. September 1, 2003;
Eff. June 1, ~~2004.~~ 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0903 is proposed for readoption without substantive changes as follows:

10A NCAC 13G .0903 LICENSED HEALTH PROFESSIONAL SUPPORT

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

(1) applying and removing ace bandages, ~~ted~~ 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~~ ulcer, which is a superficial ulcer presenting as an abrasion, ~~blister~~ 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 subcutaneous ~~injection;~~ injection in accordance with Rule .1004(q) except for anticoagulant medications;

~~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~~ endotracheal suctioning;

(20) administering and monitoring of tube feedings through a well-established gastrostomy tube ~~(see description in Subparagraph (14) of this Paragraph);~~ in accordance with Subparagraph (a)(14) of this Rule;

(21) the monitoring of continuous positive air pressure devices (CPAP and BIPAP);

(22) application of prescribed heat therapy;

(23) application and removal of prosthetic devices except as used in 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~~ 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~~ G.S. 90-270.90, Article 18E, for tasks listed in Subparagraphs (a)(17) and (a)(22) through (27) of this Rule;

(3) a respiratory care practitioner licensed under G.S. 90, Article 38, for tasks listed in Subparagraphs (a)(6), (11), (16), (18), ~~(19)~~ (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~~ Act in 21 NCAC 36.

(c) The facility shall assure that participation by a registered nurse, ~~occupational therapist~~ occupational therapist, respiratory care practitioner, or physical therapist in the on-site review and evaluation of the residents' health status, care ~~plan~~ plan, and care provided, as required in Paragraph (a) of this Rule, is completed within ~~the first~~ 30 days after ~~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.~~

(d) The facility shall follow-up and implement recommendations made by the licensed health professional including referral to the physician or appropriate health professional when indicated. The facility shall document follow-up on all recommendations made by the licensed health professional.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, ~~2004.~~ 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0905 is proposed for readoption with substantive changes as follows:

10A NCAC 13G .0905 ACTIVITIES PROGRAM

(a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community.

(b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities.

(c) The activity director, 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~~ 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,~~ to residents within the community, posted in a ~~prominent~~ location accessible to residents by the first day of each month, and updated when there are any changes;

(3) involve community resources, such as recreational, volunteer, ~~religious, aging and developmentally disabled associated agencies,~~ and religious organizations, to enhance the activities available to residents;

(4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program;

(5) encourage residents to participate in activities; and

(6) assure there are ~~adequate supplies,~~ supplies necessary for planned activities, ~~supervision~~ 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~~ 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~~ Residents shall have the opportunity to participate in ~~meaningful work type and~~ volunteer service activities in the ~~home~~ facility or in the ~~community, but participation shall be on an entirely voluntary basis, never forced upon residents and not assigned in place of staff.~~ community. Participation in volunteer activities shall not be required of residents and shall not involve duties that are typically performed by facility staff.

History Note: *Authority G.S. 131D-2.16; ~~143B-165;~~ 131D-4.1; 131D-4.3;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. August 3, 1992; April 1, 1987; April 1, 1984;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. October 1, 2022.

10A NCAC 13G .1005 is proposed for readoption without substantive changes as follows:

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 staff 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.~~ 2000;
Readopted Eff. October 1, 2022.

10A NCAC 13G .1006 is proposed for readoption without substantive changes as follows:

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~~ by the facility's medication storage policy and procedures.

(b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained 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,~~ routinely cleaned, include functional lighting, ventilated to circulate fresh air, large enough to store medications in an orderly manner, and located in areas other than the bathroom, kitchen or utility room. Medication carts shall be ~~clean~~ routinely cleaned and medications shall be stored in an orderly manner.

(d) ~~Accessibility to locked~~ Locked storage areas for medications shall only be by staff responsible for medication administration and administrator or ~~person in charge.~~ administrator-in-charge.

(e) Medications intended for topical or external use, except for ophthalmic, ~~otic~~ otic, and transdermal medications, shall be stored in a designated area separate from the medications intended for oral and injectable use. Ophthalmic, ~~otic~~ 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:~~ use in accordance with physicians' orders:

(1) irrigation solutions in single unit quantities exceeding 49 ml. and related diagnostic agents;

(2) diagnostic agents;

(3) vaccines; and

(4) water for injection and normal saline for injection.

~~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,~~ available to staff within the facility, stored out of sight of residents and ~~visitors~~ visitors, and stored separately from medications, and in ~~a secure and~~ an 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.~~ 2000;
Readopted Eff. October 1, 2022.

10A NCAC 13G .1208 is proposed for readoption without substantive changes as follows:

10A NCAC 13G .1208 FACILITIES TO REPORT RESIDENT DEATHS

~~For purposes of this Section, facilities licensed in accordance with G.S. 131D-2~~ The facility shall report resident deaths to the Division of Health Service ~~Regulation.~~ Regulation, in accordance with G.S. 131D-34.1.

History Note: *Authority G.S. 131D-2.4; 131D-2.16; 131D-34.1; 143B-165;*
Temporary Adoption Eff. May 1, 2001;
Eff. July 18, ~~2002.~~ 2002;
Readopted Eff. October 1, 2022.

DHSR Adult Care Licensure Section
Fiscal Impact Analysis
Permanent Rule Readoption and Amendment without Substantial Economic Impact

Agency: North Carolina Medical Care Commission

Contact Persons: Nadine Pfeiffer, DHSR Rules Review Manager, (919) 855-3811
Megan Lamphere, Adult Care Licensure Section Chief, (919) 855-3784
Shalisa Jones, Regulatory Analyst, (704) 589-6214

Impact:

Federal Government: No
State Government: No
Local Government: No
Private Entities: Yes
Substantial Impact: No

Titles of Rule Changes and N.C. Administrative Code Citation

Rule Readoptions (*See proposed text of these rules in Appendix)*
10A NCAC 13F .0404 Qualifications of Activity Director
10A NCAC 13F .0407 Other Staff Qualifications
10A NCAC 13F .0501 Personal Care Training and Competency
10A NCAC 13F .0503 Medication Administration Competency
10A NCAC 13F .1006 Medication Storage
10A NCAC 13F .1008 Controlled Substances
10A NCAC 13F .1010 Pharmaceutical Services
10A NCAC 13G .0404 Qualifications of Activity Director
10A NCAC 13G .0406 Other Staff Qualifications
10A NCAC 13G .0501 Personal Care Training and Competency
10A NCAC 13G .0503 Medication Administration Competency
10A NCAC 13G .0504 Competency Validation for Licensed Health Professional Support Tasks
10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation
10A NCAC 13G .0508 Assessment Training
10A NCAC 13G .0903 Licensed Health Professional Support
10A NCAC 13G .0905 Activities Program
10A NCAC 13G .1005 Self-Administration of Medication
10A NCAC 13G .1006 Medication Storage
10A NCAC 13G .1208 Facilities to Report Resident Deaths

Rule Amendment (*See proposed text of these rules in Appendix)*
10A NCAC 13F .0504 Competency Validation for Licensed Health Professional Support Tasks
10A NCAC 13F .0508 Assessment Training
10A NCAC 13F .0905 Activities Program
10A NCAC 13F .1207 Facilities to Report Resident Deaths

Rule Repeal
10A NCAC 13F .0502 Personal Care Training Content and Instructors
10A NCAC 13G .0502 Personal Care Training and Competency Program Approval

Authorizing Statutes: G.S. 131D-2.16; 131D-4.5; 143B-165

Introduction

The agency is proposing changes to update access to the Personal Care Training by making training available on the internet; and technical changes to align with general statutes and clarify current rule language to meet current style standards. The technical changes are proposed for clarity and consistency but do not affect current operations.

The proposed changes will generate costs and/or benefits for adult care homes and family care homes and their residents in the form of time and cost savings for new hires and providers as additional qualified professionals are exempt from completing the basic activity course. Facilities are given the additional benefit of flexibility and minor operational time savings with the inclusion of an immunizing pharmacist to complete the personal care task inhalation medication by machine. The agency does not anticipate any additional impact on state government or local government (i.e. county Departments of Social Services who monitor and conduct complaint investigations in adult care homes and family care homes) beyond their current job requirements to implement, monitor, or regulate the proposed amendments.

Periodic Review Process Background

Under the authority of G.S. 150B-21.3A, Periodic review of existing rules, the North Carolina Medical Care Commission and Rule Review Commission approved the Subchapter reports with classifications for the rules under 10A NCAC 13F Licensing of Adult Care Homes of Seven or More
Beds and 10 NCAC 13G Licensing of Family Care Homes. The rules were classified in the reports as necessary with substantive public interest. Rules 10A NCAC 13F .0404, 13F .0407, 13F .0501, 13G .0404, 13G .0406, 13G .0501, 13G .0504, 13G .0507 are being presented for readoption with substantive changes. The following rules were not identified for readoption with substantive changes based on public comment but are being proposed for amendment to correlate with the 13G rule of the same title and similar content being proposed for readoption: 10A NCAC 13F .0504, 13F .0508, 13F .0905, 13F .1207. Most of the rules for both types of assisted living residences, adult care homes of seven beds or more and family care homes, are the same with the primary exception of staffing and physical plant requirements since they generally serve the same population based on need for care and services. Therefore, the 13F rules corresponding to the 13G rules being proposed for readoption with substantive changes are being amended concurrently to assure this traditional consistency. The rules proposed for amendment, while not receiving comment for substantive change, are being amended for clarification and updating purposes. The following rules were identified for readoption without substantive changes:10A NCAC 13F .0503, 13F .1006, 13F .1008, 13F .1010, 13G .0503, 13G .0503, 13G .0508, 13G .0903, 13G .0905, 13G .1005, 13G .1006, 13G .1208. Rules 10A NCAC 13F. 0502 and 13G .0502 are being readopted as repeals and will not be discussed in this analysis.

Rules Summary and Anticipated Fiscal Impact

10A NCAC 13F .0404 and 13G .0404 Qualifications of Activity Director: This rule outlines the qualification requirements of an activity director. The rule is currently written to allow the activity director to meet a minimum educational requirement of either a high school diploma, certification under the GED program or passing an alternative examination established by the department. Activity directors must also complete a 'basic activity course" unless they hold a related professional certification.

The agency proposes to remove the alternate examination option for meeting minimum education requirements. Moving forward, the activity director must have either a high school diploma or GED.

Review of the data provided by the NC Division of Health Service Regulation, Health Care Personnel Education and Credentialing Section, reveals the total test takers for the alternate exam in 2021 was 25. Due to the minimal amount of times the test has been administered, this change will have minimum impact.

In Item (2) the rule was updated to include additional exemptions from the required basic activity course including having two years of experience in a social or recreation program within the last five years in a health care setting or being an occupational therapist or occupation therapy assistant.

Activity directors plan and oversee engaging activities in adult and family care homes to enhance the quality of life of residents. Proper knowledge of planning and implementing activity programs is essential to have a successful activity program. The agency believes that on-the job experience or occupational therapy education provides the necessary knowledge and skills to fulfill this role. The proposed changes allow facilities to hire qualified and experienced individuals for the activity director position without the individuals being required to take the basic activity course upon hire, ultimately starting the position without any further mandated requirements.

Fiscal Impact: Activity director hires that qualify for the exemption from the basic activity course will ultimately save time and money associated with the completion of the course. This basic activity course requires between 52-60 hours of class training and 25-33 hours of practicum. The cost for this course ranges from $300.00-$435.00 per person. Potential cost savings associated with payment for the course and supplies depends on the agreement between staff and providers regarding responsibility for payment of the course. The exemption offers time savings for staff as the requirement for class training and practicum would not be required.

10A NCAC 13F .0407 and 13G .0406 Other Staff Qualifications: The rule was modified to include the existing requirement for examination and screening for controlled substances in accordance with N.C. Gen. Stat. 131D-45 for the purpose of capturing staff qualifications in a comprehensive manner. Technical changes were also made to this rule to update statutory references.

There are no additional costs for providers to have the examination and screening results as they are currently required by statute to ensure all related examination and screening information are maintained confidentially. Additionally, there is no fiscal impact as a result of updating the statutes.

10A NCAC 13F .0501 and 13G .0501 Personal Care Training and Competency: Technical changes were made to be consistent with current writing styles, to provide the web link for the free training program and to specify the divisions responsible for reviewing employee training. Additionally, the language of

paragraph (a) was changed from "adult care home" to "facility" to be consistent with other paragraphs of the rule.

1. Paragraph (a) previously required individuals to mail a request and pay for copies of the 80-hour training and competency evaluation program. The proposed language provides the website address were the 80-hour training and competency evaluation program is available at no cost. Technical changes are also proposed to bring the rule in alignment with the repeal of 10A NCAC 13F .0502 and 13G .0502 by including the content for the training requirements.

There is no fiscal impact as a result providing free access to the training and competency evaluation program beyond improving awareness of where and how to access the program.

2. Paragraph (b) currently requires providers to maintain copies of employees' successful completion of the 80-hour training and competency evaluation program for review. The proposed rule language provides clarification by listing the agencies that will review the documents. The Division of Health Service Regulation and Department of Social Services currently review the documents as needed during survey and monitoring activities.

3. The proposed language in Paragraph (c) was replaced by language in Paragraph (d). The rule also clarified the documentation would be available for the Division of Health Service Regulation and Department of Social Services.

The revisions do not change how this rule is implemented but simplifies the interpretation of the rule by including the training and competency requirements before discussing reasons for exemptions.

4. In October 2017, N.C. Gen. Stat. 131D-4.3, required personal aides to have a minimum 80 hours of training. The proposed rule language allows staff who completed personal care aide training prior to the effective date of the statute to have trainings grandfathered based on the rules in effect at the time of training. The proposed language in Paragraph (d) was updated to reflect the current statutory training requirements.

There is no cost to implement these requirements as facilities have been required to comply with the general statute since it was established in 2017.

10A NCAC 13F .0504 and 13G .0504 Competency Validation for Licensed Health Professional Support Tasks: The proposed changes include an additional task that can be validated by a licensed health professional and included an additional licensed health professional to complete validations. The proposed change ensures that all health professionals who have the qualifications are allowed to complete competency validations. Technical changes were also made to be consistent with current writing styles.

1. The personal care task of "inhalation medication by machine" has been added as a task a pharmacist can validate; this change updates the rules to conform with existing pharmacist licensure laws and do not expand their scope of practice.

The proposed rules would also allow an immunizing pharmacist to validate the personal care task of "medication administration through injection."

Rationale: Due to the most recent pandemic COVID-19, pharmacists now administer the COVID-19 vaccines and other vaccines but only if they are designated as an immunizing pharmacist. Immunizing pharmacists are currently required to complete the training for the Long Acting IM administration as indicated in S.L. 2021-3 and G.S. 90-

85.15B. The immunizing pharmacist was added to give facilities the option to utilize an additional appropriate licensed health professional to validate the personal care task "medication administration through injection."

Fiscal Impact: The intent of this proposed change was to ensure each health professional qualified to competency validate medication administration via injection was proactively given the permission to complete the task, giving facilities the maximum amount of flexibility, however there is no significant impact. While this may result in minor operational time savings, the main intent was to make sure that the rules are comprehensive and treat professionals consistently based on their qualifications.

2. The rules as written use specific language such as "adult care home" in 13F .0504 and "family care home" in 13G .0504. The language has been updated in both rules to "facility". The rules as written also include the term "personnel" which has been updated to "staff". Reference to the occupational laws that give licensed professional authority to complete validation tasks was updated to provide clarity. Additional language regarding competency validation was included to make clear what needed to occur prior to staff performing tasks. These technical changes have no additional impact beyond improving rule clarity.

10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation: The rule as written included an exemption from the training if the staff were deemed physically incapable of performing procedures by a licensed physician. The proposed language includes the use of one-way valve pocket mask for CPR trained staff for resuscitation.

The proposed language aligns with the current language in 10 NCAC 13F .0507 and updates outdated requirements for CPR training and to now include the use of a pocket mask to utilize when performing CPR.

Fiscal Impact: None

10A NCAC 13F .0905 and 13G .0905 Activities Program: Technical changes were made to be consistent with current writing styles and to provide clarity. The rule as written included an exemption for homes that care exclusively for residents with HIV disease. The proposed language removes the exemption to align with current licensing practices.

The proposed language aligns with current statutes, rules and licensing criteria. Current licensing laws and regulations only differentiate license types by adult care home or family care home, facilities that serve only individuals age 55 and older, and facilities that operate a special care unit. Licenses are otherwise not specific to disease or condition. There are no facilities licensed to serve only individuals with HIV disease. Additional language was included to provide clarity regarding resident's participation in volunteer activities.

Fiscal impact: None

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1 USDA Dietary Guidelines for Americans, 2020-2025

2 Data from the Adult Care Homes 2020 Facility License Renewal Applications

3(BMJ, 2021) "Effect of dietary sources of calcium and protein on hip fractures and falls in older adults in residential care: cluster randomized controlled trial"

Appendix

10A NCAC 13F .0404 is proposed for readoption with substantive changes as follows:

10A NCAC 13F .0404 QUALIFICATIONS OF ACTIVITY DIRECTOR

~~There shall be a designated adult~~ Adult care ~~home~~ homes shall have an activity director who meets the following qualifications:

(1) The activity director ~~(employed~~ hired on or after ~~August 1, 1991)~~ September 30, 2022 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.~~ Program.

(2) The activity director hired on or after ~~July 1, 2005~~ September 30, 2022 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.~~ An activity director shall be exempt from the required basic activity course if one or more of the following applies:

(a) be a licensed recreational therapist or be eligible for certification as a therapeutic recreation specialist as defined by the North Carolina Recreational Therapy Licensure Act in accordance with G.S. 90C;

(b) have two years of experience working in a social or recreation program within the last five years, one year of which was full-time in a patient activities program in a health care setting;

(c) be a licensed occupational therapist or licensed occupational therapy assistant in accordance with G.S. 90, Article 18D; or

(d) be certified as an Activity Director by the National Certification Council for Activity Professionals.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1987; April 1, 1984;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, 2004;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. October 1, 2022.

10A NCAC 13F .0407 is proposed for readoption with substantive changes as follows:

10A NCAC 13F .0407 OTHER STAFF QUALIFICATIONS

(a) Each staff person at an adult care home shall:

(1) have a job description that reflects ~~actual~~ the positions, duties and responsibilities and is signed by the administrator and the employee;

(2) be able to ~~apply~~ implement all of the adult care home's accident, fire ~~safety~~ 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~~ the information from unauthorized use and ~~disclosure.~~ disclosure, in accordance with

~~Note: G.S. 131D 2(b)(4), 131D 21(6),~~ 131D-21(6) and ~~131D 21.1 govern the disclosure of such information;~~ 131D 21.1;

(4) not hinder or interfere with the exercise of the rights guaranteed under the Declaration of Residents' Rights in G.S. 131D-21;

(5) have no 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~~ 131D-40;

(8) have results of the examination and screening for the presence of controlled substances in accordance with G.S. 131D-45;

~~(8)~~ (9) maintain a ~~valid~~ current driver's license if responsible for transportation of residents; and

~~(9)~~ (10) be willing to ~~work~~ cooperate with ~~bona fide~~ state and local inspectors ~~and the monitoring and licensing agencies toward meeting and maintaining~~ when determining and maintaining compliance with the rules of this Subchapter.

(b) ~~Any~~ At all times, there shall be at least one staff ~~member left~~ person in the facility ~~left~~ in charge of ~~the~~ resident care ~~of residents~~ who shall be 18 years or older.

(c) If licensed practical nurses are employed by the facility and practicing in their licensed capacity as governed by ~~their practice act and occupational licensing laws,~~ the North Carolina Board of Nursing, there shall be ~~continuous availability of~~ a registered nurse ~~consistent~~ available in accordance with the Rules set forth in ~~Rules~~ 21 NCAC 36 ~~.0224(i)~~ .0224 and 21 NCAC 36 ~~.0225.~~ .0225, which are hereby incorporated by reference including subsequent amendments.

~~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~~ 131D 4.5(4); 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Temporary Amendment Eff. September 1, 2003; July 1, 2003.
Amended Eff. June 1, ~~2004.~~ 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13F .0501 is proposed for readoption with substantive changes as follows:

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

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

(a) ~~An adult care home~~ The facility shall assure that staff who provide or directly supervise staff who provide personal care to residents ~~successfully~~ complete an 80-hour personal care training and competency evaluation program established or approved by the Department. For the purpose of this Rule, ~~Directly supervise~~ "Directly supervise" means being on duty in the facility to oversee or direct the performance of staff duties. ~~Copies~~ A copy of the 80-hour training and competency evaluation program ~~are~~ is available ~~at the cost of printing and mailing by contacting the Division of Health Service Regulation, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708.~~ online at https://info.ncdhhs.gov/dhsr/acls/training/PCA-trainingmanual.html, at no cost. The 80-hour personal care training and competency evaluation program curriculum shall include:

(1) observation and documentation skills;

(2) basic nursing skills, including special health-related tasks;

(3) activities of daily living and personal care skills;

(4) cognitive, behavioral, and social care;

(5) basic restorative services; and

(6) residents' rights as established by G.S. 131D-21.

(b) The facility shall assure that training specified in Paragraph (a) of this Rule is ~~successfully~~ completed within six months after hiring for staff hired after ~~September 1, 2003.~~ October 1, 2022. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for ~~review.~~ review by the Division of Health Service Regulation and the county department of social services.

(c) The facility shall assure that staff who perform or directly supervise staff who perform personal care receive training and supervision on the performance of individual job assignments prior to meeting the training and competency requirements of this Rule. Documentation of training shall be maintained in the facility and available for review by the Division of Health Service Regulation and the county department of social services.

~~(c)~~ (d) The Department shall exempt staff from the 80-hour training and competency evaluation program who are:

(1) licensed health professionals;

(2) listed on the Nurse Aide Registry; or

(3) documented as having ~~successfully~~ completed ~~a 40-45 or 75-80 hour training program or competency evaluation program approved by the Department since January 1, 1996 according to Rule .0502 of this Section.~~ one of the following previously approved training programs:

(A) a 40-hour or 75-hour training and competency evaluation program prior to July 1, 2000; or

(B) a 45-hour or 80-hour training and competency evaluation program for training exemption from July 1, 2000 through August 31, 2003.

~~(d) The facility shall assure that staff who perform or directly supervise staff who perform personal care 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. Documentation of the on-the-job training shall be maintained in the facility and available for review.~~

History Note: *Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 143B-165;*
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, ~~2004.~~ 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13F .0503 is proposed for readoption without substantive changes as follows:

10A NCAC 13F .0503 MEDICATION ADMINISTRATION COMPETENCY

(a) The competency evaluation for medication administration required in Rule .0403 of this Subchapter shall consist of a written examination and a clinical skills evaluation to determine competency in the following areas:

(1) medical abbreviations and terminology;
(2) transcription of medication orders;
(3) obtaining and documenting vital signs;
(4) procedures and tasks involved with the preparation and administration of oral (including liquid, sublingual and inhaler), topical (including transdermal), ophthalmic, otic, and nasal medications;
(5) infection control procedures;
(6) documentation of medication administration;
(7) monitoring for reactions to medications and procedures to follow when there appears to be a change in the resident's condition or health status based on those reactions;
(8) medication storage and disposition;
(9) ~~regulations~~ rules pertaining to medication administration in adult care facilities; and
(10) the facility's medication administration policy and procedures.

(b) An individual shall score at least 90% on the written examination which shall be a standardized examination established by the Department.

(c) A certificate of successful completion of the written examination shall be issued to each participant ~~successfully completing the examination.~~ who successfully completes the examination as required in Paragraph (b) of this rule. 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~~ licensed 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 listed in Subparagraphs (a)(4), (a)(7), (a)(11), (a)(14), and (a)(15) as specified in Rule .0903 of this Subchapter.

(e) The Medication Administration Skills Validation Form shall be used to document successful completion of the clinical skills validation portion of the competency evaluation for those medication administration tasks to be performed in the facility employing the medication aide. The form requires the following:

(1) name of the staff and adult care home;

(2) satisfactory completion date of demonstrated competency of task or skill with the instructor's initials or signature;

(3) if staff needs more training on skills or tasks, it should be noted with the instructor's signature; and

(4) staff and instructor signatures and date after completion of tasks.

Copies of this form and instructions for its use may be obtained at no cost ~~by contacting the Adult Care Licensure Section, Division of Health Service Regulation, 2708 Mail Service Center, Raleigh, NC 27699-2708.~~ on the Adult Care Licensure website, https://info.ncdhhs.gov/dhsr/acls/pdf/medchklst.pdf. The completed form shall be maintained and available for review in the facility and is not transferable from one facility to another.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. January 1, 2000; December 1, 1999;
Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, ~~2004.~~ 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13F .0503 is proposed for readoption without substantive changes as follows:

10A NCAC 13F .0503 MEDICATION ADMINISTRATION COMPETENCY

(a) The competency evaluation for medication administration required in Rule .0403 of this Subchapter shall consist of a written examination and a clinical skills evaluation to determine competency in the following areas:

(1) medical abbreviations and terminology;

(2) transcription of medication orders;

(3) obtaining and documenting vital signs;

(4) procedures and tasks involved with the preparation and administration of oral (including liquid, sublingual and inhaler), topical (including transdermal), ophthalmic, otic, and nasal medications;

(5) infection control procedures;

(6) documentation of medication administration;

(7) monitoring for reactions to medications and procedures to follow when there appears to be a change in the resident's condition or health status based on those reactions;

(8) medication storage and disposition;

(9) ~~regulations~~ rules pertaining to medication administration in adult care facilities; and

(10) the facility's medication administration policy and procedures.

(b) An individual shall score at least 90% on the written examination which shall be a standardized examination established by the Department.

(c) A certificate of successful completion of the written examination shall be issued to each participant ~~successfully completing the examination.~~ who successfully completes the examination as required in Paragraph (b) of this rule. 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~~ licensed 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 listed in Subparagraphs (a)(4), (a)(7), (a)(11), (a)(14), and (a)(15) as specified in Rule .0903 of this Subchapter.

(e) The Medication Administration Skills Validation Form shall be used to document successful completion of the clinical skills validation portion of the competency evaluation for those medication administration tasks to be performed in the facility employing the medication aide. The form requires the following:

(1) name of the staff and adult care home;

(2) satisfactory completion date of demonstrated competency of task or skill with the instructor's initials or signature;

(3) if staff needs more training on skills or tasks, it should be noted with the instructor's signature; and

(4) staff and instructor signatures and date after completion of tasks.

Copies of this form and instructions for its use may be obtained at no cost ~~by contacting the Adult Care Licensure Section, Division of Health Service Regulation, 2708 Mail Service Center, Raleigh, NC 27699-2708.~~ on the Adult Care Licensure website, https://info.ncdhhs.gov/dhsr/acls/pdf/medchklst.pdf. The completed form shall be maintained and available for review in the facility and is not transferable from one facility to another.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. January 1, 2000; December 1, 1999;
Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, ~~2004.~~ 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13F .1006 is proposed for readoption without substantive changes as follows:

10A NCAC 13F .1006 MEDICATION STORAGE

(a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified ~~in~~ by the adult care home's medication storage policy and procedures.

(b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained 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,~~ routinely cleaned, include functional lighting, ventilated to circulate fresh air, large enough to store medications in an orderly manner, and located in areas other than the bathroom, kitchen or utility room. Medication carts shall be ~~clean~~ routinely cleaned and medications shall be stored in an orderly manner.

(d) ~~Accessibility to locked~~ Locked storage areas for medications shall only be accessible by staff responsible for medication administration and administrator or ~~person in charge.~~ administrator-in-charge.

(e) Medications intended for topical or external use, except for ophthalmic, ~~otic~~ otic, and transdermal medications shall be stored in a designated area separate from the medications intended for oral and injectable use. Ophthalmic, ~~otic~~ otic, and transdermal medications may be stored with medications intended for oral and injectable use. Medications shall be stored apart from cleaning agents and hazardous chemicals.

(f) Medications requiring refrigeration shall be stored at 36 degrees F to 46 degrees F (2 degrees C to 8 degrees C).

(g) Medications shall not be stored in a refrigerator containing non-medications and non-medication related items, except when stored in a separate container. The container shall be locked when storing medications unless the refrigerator is locked or is located in a locked medication area.

(h) The facility may possess a stock of non-prescription medications or the following prescription legend medications for general or common ~~use:~~ use in accordance with physicians' orders:

(1) irrigation solutions in single unit quantities exceeding 49 ml. and related diagnostic agents;

(2) diagnostic agents;

(3) vaccines; and

(4) water for injection and normal saline for injection.

~~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,~~ available to staff within the facility, stored out of sight of residents and ~~visitors~~ visitors, and stored separately from medications, and in ~~a secure and~~ an orderly manner.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. October 1, 2022.

10A NCAC 13F .1008 is proposed for readoption without substantive changes as follows:

10A NCAC 13F .1008 CONTROLLED SUBSTANCES

(a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, ~~administration~~ 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~~ 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~~ 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~~ 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~~ destruction, and the initials or signature of the person destroying the substance.

(h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement ~~agency~~ agency, and Health Care Personnel Registry as required by ~~state~~ State law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. October 1, 2022.

10A NCAC 13F .1010 is proposed for readoption without substantive changes as follows:

10A NCAC 13F .1010 PHARMACEUTICAL SERVICES

(a) An adult care home shall allow the residents the right to choose a pharmacy provider as long as the pharmacy provides services that are in accordance with requirements of this Section and all applicable ~~state~~ State and federal rules and regulations and the facility's medication management policies and procedures.

(b) There shall be a current, written agreement with a licensed pharmacist or a prescribing practitioner for pharmaceutical care services in accordance with Rule .1009 of this Section. The written agreement shall include a statement of the responsibility of each party.

(c) The facility shall assure the provision of pharmaceutical services to meet the needs of the residents including procedures that assure the accurate ordering, ~~receiving~~ 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~~ 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:~~ include:

(A) the name and strength of the medication;

(B) the directions for administration as prescribed by the resident's physician; and

(C) any cautionary information from the original prescription package if the information is not on the container released for the leave of absence;

(3) ~~The~~ the resident's medication shall be provided in a capped or closed container that will protect the medications from contamination and spillage; and

(4) ~~Labeling~~ labeling of each of the resident's individual medication containers for the leave of absence shall be legible, include at least the name of the resident and the name and strength of the medication, and be affixed to each container.

The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation of the quantities of medications released from and returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications' release from and return to the facility.

(e) The facility shall assure that accurate records of the receipt, use, and disposition of medications are maintained in the facility and available upon request for review.

(f) A facility with 12 or more beds shall have a current, written agreement with a pharmacy provider for dispensing services. The written agreement shall include a statement of the responsibility of each party.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. July 1, 2005;
Amended Eff. April 1, ~~2015.~~ 2015;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0404 is proposed for readoption with substantive changes as follows:

10A NCAC 13G .0404 QUALIFICATIONS OF ACTIVITY DIRECTOR

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

(1) The activity director ~~(employed~~ hired on or after ~~August 1, 1991)~~ September 30, 2022 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.~~ Program.

(2) The activity director hired on or after ~~July 1, 2005~~ September 30, 2022 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 Professional 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.~~ An activity director shall be exempt from the required basic activity course if one or more of the following applies:

(a) be a licensed recreational therapist or be eligible for certification as a therapeutic recreation specialist as defined by the North Carolina Recreational Therapy Licensure Act in accordance with G.S. 90C;

(b) have two years of experience working in a social or recreation program within the last five years, one year of which was full-time in a patient activities program in a health care setting;

(c) be a licensed occupational therapist or licensed occupational therapy assistant in accordance with G.S. 90, Article 18D; or

(d) be certified as an Activity Director by the National Certification Council for Activity Professionals.

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.~~ 2005;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0406 is proposed for readoption with substantive changes as follows:

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~~ the positions, ~~duties~~ duties, and responsibilities and is signed by the administrator and the employee;

(2) be able to ~~apply~~ implement all of the family care home's accident, fire ~~safety~~ 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~~ the information from unauthorized use and ~~disclosure;~~ disclosure, in accordance with ~~Note: G.S. 131D-2(b)(4),~~ G.S. 131D-21(6), and ~~G.S. 131D-21.1 govern the disclosure of such the information;~~ G.S. 131D 21.1;

(4) not hinder or interfere with the exercise of the rights guaranteed under the Declaration of Residents' Rights in G.S. 131D-21;

(5) have no 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) have results of the examination and screening for the presence of controlled substances in accordance with G.S. 131D-45;

~~(8)~~ (9) maintain a ~~valid~~ current driver's license if responsible for transportation of residents; and

~~(9)~~ (10) be willing to ~~work~~ cooperate with ~~bona fide~~ state and local inspectors ~~and the monitoring and licensing agencies toward meeting and maintaining~~ when determining and maintaining compliance with the rules of this Subchapter.

(b) ~~Any~~ At all times, there shall be at least one staff ~~member~~ person in the facility ~~left~~ in charge of ~~the~~ resident care ~~of residents~~ who shall be 18 years or older.

(c) If licensed practical nurses are employed by the facility and practicing in their licensed capacity as governed by ~~their practice act and occupational licensing laws,~~ the North Carolina Board of Nursing, there shall be ~~continuous availability of~~ a registered nurse ~~consistent~~ available in accordance with the Rules set forth in ~~Rules~~ 21 NCAC 36 ~~.0224(i)~~ .0224 and 21 NCAC 36 ~~.0225.~~ .0225, which are hereby incorporated by reference including subsequent amendments.

~~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.~~ 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0501 is proposed for readoption with substantive changes as follows:

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.~~

(a) The facility shall assure that staff who provide or directly supervise staff who provide personal care to residents complete an 80-hour personal care training and competency evaluation program established by the Department. For the purpose of this Rule, "Directly supervise" means being on duty in the facility to oversee or direct the performance of staff duties. A copy of the 80-hour training and competency evaluation program is available online at https://info.ncdhhs.gov/dhsr/acls/training/PCA-trainingmanual.html, at no cost. The 80-hour personal care training and competency evaluation program curriculum shall include:

(1) observation and documentation skills;

(2) basic nursing skills, including special health-related tasks;

(3) activities of daily living and personal care skills;

(4) cognitive, behavioral, and social care;

(5) basic restorative services; and

(6) residents' rights as established by G.S. 131D-21.

(b) The facility shall assure that training specified in Paragraph (a) of this Rule is completed within six months after hiring for staff hired after October 1, 2022. Documentation of the successful completion of the 80-hour training and competency evaluation

program shall be maintained in the facility and available for review by the Division of Health Service Regulation and the county department of social services.

(c) The facility shall assure that staff who perform or directly supervise staff who perform personal care receive training and supervision for the performance of individual job assignments prior to meeting the training and competency requirements of this Rule. Documentation of training shall be maintained in the facility and available for review by the Division of Health Service Regulation and the county department of social services.

(d) The Department shall exempt staff from the 80-hour training and competency evaluation program who are:

(1) licensed health professionals;

(2) listed on the Nurse Aide Registry; or

(3) documented as having completed one of the following previously approved training programs:

(A) a 20-hour or 75-hour training and competency evaluation program prior to July 1, 2000; or

(B) a 25-hour or 80-hour training and competency evaluation program from July 1, 2000 through September 30, 2017.

History Note: *Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 143B-165;*
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, ~~2000.~~ 2000;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0503 is proposed for readoption without substantive changes as follows:

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:

(1) medical abbreviations and terminology;

(2) transcription of medication orders;

(3) obtaining and documenting vital signs;

(4) procedures and tasks involved with the preparation and administration of oral (including liquid, sublingual and inhaler), topical (including transdermal), ophthalmic, otic, and nasal medications;

(5) infection control procedures;

(6) documentation of medication administration;

(7) monitoring for reactions to medications and procedures to follow when there appears to be a change in the resident's condition or health status based on those reactions;

(8) medication storage and disposition;

(9) ~~regulations~~ rules pertaining to medication administration in adult care facilities; and

(10) the facility's medication administration policy and procedures.

(b) An individual shall score at least 90% on the written examination which shall be a standardized examination established by the Department.

(c) A certificate of successful completion of the written examination shall be issued to each participant ~~successfully completing the examination.~~ who successfully completes the examination as required in Paragraph (b) of this Rule. 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~~ licensed 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 listed in Subparagraphs (a)(4), (a)(7), (a)(11), (a)(14), and (a)(15) as specified in Rule .0903 of this Subchapter.

(e) The Medication Administration Skills Validation Form shall be used to document successful completion of the clinical skills validation portion of the competency evaluation for those medication administration tasks to be performed in the facility employing the medication aide. The form requires the following:

(1) name of the staff and adult care home;

(2) satisfactory completion date of demonstrated competency of task or skill with the instructor's initials or signature;

(3) if staff needs more training on skills or tasks, it should be noted with the instructor's signature; and

(4) staff and instructor signatures and date after completion of tasks.

Copies of this form and instructions for its use may be obtained at no cost ~~by contacting the Adult Care Licensure Section, Division of Health Service Regulation, 2708 Mail Service Center, Raleigh, NC 27699-2708~~. on the Adult Care Licensure website, https://info.ncdhhs.gov/dhsr/acls/pdf/medchklst.pdf. The completed form shall be maintained and available for review in the facility and is not transferable from one facility to another.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. January 1, 2000; December 1, 1999;
Eff. July 1, ~~2000.~~ 2000;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0504 is proposed for readoption with substantive changes as follows:

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

(a) ~~A family care home~~ The facility shall assure that ~~non-licensed personnel and licensed personnel~~ non-licensed staff and licensed staff not practicing in their licensed capacity ~~as governed by their practice act and~~ in accordance with 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~~ Subchapter. The facility shall assure the competency validation occurs 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 any of the personal care tasks specified in Subparagraphs (a)(1) through (28) of Rule .0903 of this Subchapter.

(2) In lieu of a registered nurse, a licensed 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)~~ (19), and (21) of Rule .0903 of this Subchapter.

(3) In lieu of a registered nurse, a ~~registered~~ licensed pharmacist may validate the competency of staff who perform the personal care ~~task~~ tasks specified in Subparagraph (a)(8) and (11) of Rule .0903 of this Subchapter. An immunizing pharmacist may validate the competency of staff who perform the personal care task specified in Subparagraph (a)(15) of Rule .0903 of this Subchapter.

(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)~~ 131D-2.2(a) 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.~~ relocation of the resident.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. September 1, 2003;
Eff. July 1, ~~2004.~~ 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0507 is proposed for readoption with substantive changes as follows:

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.~~ The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. September 1, 2003;
Eff. July 1, ~~2004.~~ 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0508 is proposed for readoption without substantive changes as follows:

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 Resident Assessment Self-Instructional Manual for Adult Care Homes herein incorporated by reference including subsequent amendments and editions. The instruction manual on resident assessment is available on the ~~internet~~ Adult Care Licensure 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.~~ https://info.ncdhhs.gov/dhsr/acls/pdf/assessmentmanual.pdf, at no cost.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. September 1, 2003;
Eff. June 1, ~~2004.~~ 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0903 is proposed for readoption without substantive changes as follows:

10A NCAC 13G .0903 LICENSED HEALTH PROFESSIONAL SUPPORT

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

(1) applying and removing ace bandages, ~~ted~~ 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~~ ulcer, which is a superficial ulcer presenting as an abrasion, ~~blister~~ 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 subcutaneous ~~injection;~~ injection in accordance with Rule .1004(q) except for anticoagulant medications;

~~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~~ endotracheal suctioning;

(20) administering and monitoring of tube feedings through a well-established gastrostomy tube ~~(see description in Subparagraph (14) of this Paragraph);~~ in accordance with Subparagraph (a)(14) of this Rule;

(21) the monitoring of continuous positive air pressure devices (CPAP and BIPAP);

(22) application of prescribed heat therapy;

(23) application and removal of prosthetic devices except as used in 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~~ 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~~ G.S. 90-270.90, Article 18E, for tasks listed in Subparagraphs (a)(17) and (a)(22) through (27) of this Rule;

(3) a respiratory care practitioner licensed under G.S. 90, Article 38, for tasks listed in Subparagraphs (a)(6), (11), (16), (18), ~~(19)~~ (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~~ Act in 21 NCAC 36.

(c) The facility shall assure that participation by a registered nurse, ~~occupational therapist~~ occupational therapist, respiratory care practitioner, or physical therapist in the on-site review and evaluation of the residents' health status, care ~~plan~~ plan, and care provided, as required in Paragraph (a) of this Rule, is completed within ~~the first~~ 30 days after ~~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.~~

(d) The facility shall follow-up and implement recommendations made by the licensed health professional including referral to the physician or appropriate health professional when indicated. The facility shall document follow-up on all recommendations made by the licensed health professional.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, ~~2004.~~ 2004;
Readopted Eff. October 1, 2022.

10A NCAC 13G .0905 is proposed for readoption with substantive changes as follows:

10A NCAC 13G .0905 ACTIVITIES PROGRAM

(a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community.

(b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities.

(c) The activity director, 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~~ 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,~~ to residents within the community, posted in a ~~prominent~~ location accessible to residents by the first day of each month, and updated when there are any changes;

(3) involve community resources, such as recreational, volunteer, ~~religious, aging and developmentally disabled associated agencies,~~ and religious organizations, to enhance the activities available to residents;

(4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program;

(5) encourage residents to participate in activities; and

(6) assure there are ~~adequate supplies,~~ supplies necessary for planned activities, ~~supervision~~ 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~~ 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~~ Residents shall have the opportunity to participate in ~~meaningful work type and~~ volunteer service activities in the ~~home~~ facility or in the ~~community, but participation shall be on an entirely voluntary basis, never forced upon residents and not assigned in place of staff.~~ community. Participation in volunteer activities shall not be required of residents and shall not involve duties that are typically performed by facility staff.

History Note: *Authority G.S. 131D-2.16; ~~143B-165;~~ 131D-4.1; 131D-4.3;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. August 3, 1992; April 1, 1987; April 1, 1984;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. October 1, 2022.

10A NCAC 13G .1005 is proposed for readoption without substantive changes as follows:

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 staff 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.~~ 2000;
Readopted Eff. October 1, 2022.

10A NCAC 13G .1006 is proposed for readoption without substantive changes as follows:

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~~ by the facility's medication storage policy and procedures.

(b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained 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,~~ routinely cleaned, include functional lighting, ventilated to circulate fresh air, large enough to store medications in an orderly manner, and located in areas other than the bathroom, kitchen or utility room. Medication carts shall be ~~clean~~ routinely cleaned and medications shall be stored in an orderly manner.

(d) ~~Accessibility to locked~~ Locked storage areas for medications shall only be by staff responsible for medication administration and administrator or ~~person in charge.~~ administrator-in-charge.

(e) Medications intended for topical or external use, except for ophthalmic, ~~otic~~ otic, and transdermal medications, shall be stored in a designated area separate from the medications intended for oral and injectable use. Ophthalmic, ~~otic~~ 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:~~ use in accordance with physicians' orders:

(1) irrigation solutions in single unit quantities exceeding 49 ml. and related diagnostic agents;

(2) diagnostic agents;

(3) vaccines; and

(4) water for injection and normal saline for injection.

~~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,~~ available to staff within the facility, stored out of sight of residents and ~~visitors~~ visitors, and stored separately from medications, and in ~~a secure and~~ an 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.~~ 2000;
Readopted Eff. October 1, 2022.

10A NCAC 13G .1208 is proposed for readoption without substantive changes as follows:

10A NCAC 13G .1208 FACILITIES TO REPORT RESIDENT DEATHS

~~For purposes of this Section, facilities licensed in accordance with G.S. 131D-2~~ The facility shall report resident deaths to the Division of Health Service ~~Regulation.~~ Regulation, in accordance with G.S. 131D-34.1.

History Note: *Authority G.S. 131D-2.4; 131D-2.16; 131D-34.1; 143B-165;*
Temporary Adoption Eff. May 1, 2001;
Eff. July 18, ~~2002.~~ 2002;
Readopted Eff. October 1, 2022.

10A NCAC 13F .0504 is proposed for amendment as follows:

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

(a) ~~An adult care home~~ The facility shall assure that ~~non-licensed personnel and licensed personnel~~ non-licensed staff and licensed staff not practicing in their licensed capacity ~~as governed by their practice act and~~ in accordance with 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~~ Subchapter. The facility shall assure the competency validation occurs 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 any of the personal care tasks specified in Subparagraphs (a)(1) through (28) of Rule .0903 of this Subchapter.

(2) In lieu of a registered nurse, a licensed 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), (a)(11), (a)(16), (a)(18), ~~(a)(19)~~ (a)(19), and (a)(21) of Rule .0903 of this Subchapter.

(3) In lieu of a registered nurse, a ~~registered~~ licensed pharmacist may validate the competency of staff who perform the personal care ~~task~~ tasks specified in Subparagraph (a)(8) and (a)(11) of Rule .0903 of this Subchapter. An immunizing pharmacist may validate the competency of staff who perform the personal care task specified in Subparagraph (a)(15) of Rule .0903 of this Subchapter.

(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-2.2(a) 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.~~ relocation of the resident.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. September 1, 2003;
Eff. July 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, 2018;
Amended Eff. October 1, 2022; July 1, 2021.

10A NCAC 13F .0508 is proposed for amendment as follows:

10A NCAC 13F .0508 ASSESSMENT TRAINING

The person or persons designated by the administrator to perform resident assessments as required by Rule .0801 of this Subchapter shall ~~successfully~~ complete training on resident assessment established by the Department before performing the required assessments. Registered nurses are exempt from the assessment training. The Resident Assessment Self-Instructional Manual for Adult Care Homes herein incorporated by reference including subsequent amendments and editions. The instruction manual on resident assessment is available on the ~~internet~~ Adult Care Licensure 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.~~ https://info.ncdhhs.gov/dhsr/acls/pdf/assessmentmanual.pdf, at no cost.

History Note: *Authority G.S. 131D-2.15; 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. September 1, 2003;
Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~2018.~~ 2018;
Amended Eff. October 1, 2022.

10A NCAC 13F .0905 is proposed for amendment as follows:

10A NCAC 13F .0905 ACTIVITIES PROGRAM

(a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community.

(b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities.

(c) The activity director, 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~~ 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,~~ to residents within the community, posted in a ~~prominent~~ location accessible to residents by the first day of each month, and updated when there are any changes;

(3) involve community resources, such as recreational, volunteer, ~~religious, aging and developmentally disabled associated agencies,~~ and religious organizations, to enhance the activities available to residents;

(4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program;

(5) encourage residents to participate in activities; and

(6) assure there are ~~adequate supplies~~, supplies necessary for planned activities, ~~supervision~~ 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~~ 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~~ Residents shall have the opportunity to participate in ~~meaningful work type and~~ volunteer service activities in the ~~home~~ facility or in the ~~community, but participation shall be on an entirely voluntary basis, never forced upon residents and not assigned in place of staff.~~ community. Participation in volunteer activities shall not be required of residents and shall not involve duties that are typically performed by facility staff.

History Note: *Authority G.S. 131D-2.16; ~~131D-4.5; 143B-165;~~ 131D-4.1; 131D-4.3;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1987; April 1, 1984;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. July 1, 2004;
Temporary Amendment Eff. July 1, 2004 (This temporary amendment replaces the permanent rule approved by RRC on May 20, 2004);
Amended Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~2018.~~ 2018;
Amended Eff. October 1, 2022.

10A NCAC 13F .1207 is proposed for amendment as follows:

10A NCAC 13F .1207 FACILTIES TO REPORT RESIDENT DEATHS

~~For purposes of this Section, facilities licensed in accordance with G.S. 131D-2~~ The facility shall report resident deaths to the Division of Health Service ~~Regulation.~~ Regulation in accordance with G.S. 131D-34.1.

History Note: *Authority G.S. 131D-2.4; 131D-2.16; ~~131D-2.4;~~ 131D-34.1;143B-165;*
Temporary Adoption Eff. May 1, 2001;
Eff. July 18, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~2018.~~ 2018;
Amended Eff. October 1, 2022.

10A NCAC 13F .0502 is proposed for repeal as follows:

10A NCAC 13F .0502 PERSONAL CARE TRAINING CONTENT AND INSTRUCTORS

History Note: *Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 143B-165;*
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, 2000;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~2018.~~ 2018;
Repealed Eff. October 1, 2022.

10A NCAC 13G .0502 is proposed for readoption as a repeal as follows:

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

History Note: *Authority G.S. 131D-2.16; 131D-4.3; 131D-4.5; 143B-165;*
Temporary Adoption Eff. January 1, 1996;
Eff. May 1, 1997;
Temporary Amendment Eff. December 1, 1999;
Amended Eff. July 1, ~~2000.~~ 2000;
Repealed Eff. October 1, 2022.

EXHIBIT F

Deerfield Episcopal Retirement Community

NCMCC Meeting:

Friday, February 11, 2022
9:00 a.m. (ET)

Deerfield

Overview

- Deerfield Episcopal Retirement Community, Incorporated ("Deerfield) has a nearly 70 year history after being founded in 1955 as a nonprofit corporation and affiliated with the Episcopal Diocese of Western North Carolina (the "Diocese")

- Deerfield currently owns and operates a CCRC on 125-acres in Asheville, North Carolina
  - 378 Independent Living Units (126 Cottages / 252 Apartments)
  - 62 Assisted Living Units
  - 62 Skilled Nursing Beds

- Governed by a self perpetuating Board of Directors
  - Resident Council President serves as a voting ex officio member
  - Bishop of the Diocese serves as a permanent member

- Active in LeadingAge and LeadingAge North Carolina

- Deerfield is currently rated 'A' by Fitch, is accredited by the Commission on Accreditation of Rehabilitation Facilities ("CARF") and has a CMS 5-star rating in the health center

Deerfield History

- Founded in 1955 and operated as a nursing home with small cottage and apartment additions over the years

- In 1997 embarked on a major campus repositioning that included 170 apartments, 54 cottages, a new health care center offering assisted living and skilled nursing care, as well a community center featuring amenities such as formal and casual dining, a library, exercise facilities, meeting rooms and activity rooms (completed in March 2001)

- In 2008 embarked on another major campus repositioning that included 82 apartments, 20 assisted living suites, 14 nursing beds and new and expanded common spaces for programming, dining and health and wellness (completed in November 2010)

Deerfield
NCMCC Issues

Series	Amount
1997	$73,780,000
2004A	$37,505,000
2004B	$5,000,000
2004C	$10,000,000
2008A	$47,945,000
2008B	$50,035,000
2014	$24,160,000
2016	$40,060,000

Community Map and Pricing

A-118

- As a Type A Lifecare Community, when a resident moves to a higher level of care (assisted living or skilled nursing), their monthly fees remain unchanged and are based upon their independent living unit (1)

ILU Apartments (252 Units)	
Size (Sq. Ft.)	800 - 2,314
Monthly Fees	$3,018 - $4,818
Entry Fees	$223,837 - $602,048

ILU Cottages (126 Units)	
Size (Sq. Ft.)	1,316 - 2,565
Monthly Fees	$3,202 - $5,136
Entry Fees	$341,386 - $680,532

(1) Deerfield directly accepts residents to assisted living and skilled nursing; however, over 98% of the residents on campus come through independent living units.

Community Views

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Historic Utilization and Financial Performance

Historical Occupancy *(1)*

FYE September 30th	2017	2018	2019	2020	2021
Independent Living Units	96.9%	97.9%	97.1%	97.5%	97.5%
Assisted Living Units	95.5%	86.6%	91.9%	91.1%	79.8%
Skilled Nursing Beds	86.8%	89.7%	97.1%	94.2%	81.1%

(1) Deerfield has significant future resident demand and currently have a wait list consisting of 1,316 future residents.

Historical Financial Ratios

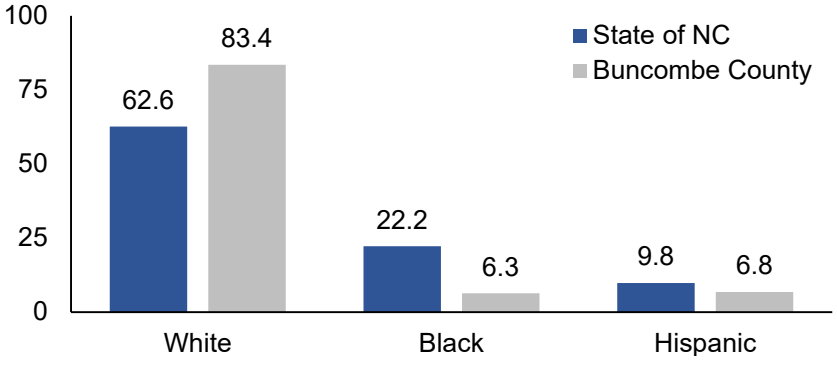
FYE September 30th	2017	2018	2019	2020	2021
Debt Service Coverage	3.71x	9.41x	3.41x	2.51x	2.64x
Days' Cash on Hand	1,184	1,243	1,288	1,295	1,438
Reserve Ratio	129%	147%	168%	186%	219%

Social Accountability and Diversity

Social Accountability

FYE September 30th	2017	2018	2019	2020	2021	5-Year Tot.
Charity Care	$883,000	$625,000	$693,000	$695,000	$746,000	$3,642,000
Community Benefits	$1,041,000	$1,225,000	$1,230,000	$1,255,000	$1,222,000	$5,973,000
Total	**$1,924,000**	**$1,850,000**	**$1,923,000**	**$1,950,000**	**$1,968,000**	**$9,615,000**
% of Revenue	**5.62%**	**5.32%**	**5.41%**	**5.40%**	**5.54%**	

*Demographic Summary**



*Source: US Census Bureau, estimate as of July 31, 2021.

Diversity

	Board	Residents (1)
Males	10	237
Females	6	389
Total	16	626
African American	1	2
Hispanic	1	-

(1) Resident population includes 30 Residents born outside the US originating from: Argentina(1), Austria(1), Bermuda(1), Brazil(1), Canada(2), Central America(1), China(1), Cuba(1), England(6), Germany(4), United Kingdom(2), Holland(2), India(1), Japan(1), Netherlands(2), Sweden(1), Syria(1) and Thailand(1).

Deerfield Charitable Foundation
Habitat for Humanity

- Launch of New Senior (55+) aging in place home ownership

- Deerfield has sponsored 12 homes over the past 3 years

Deerfield Charitable Foundation
Affordable Housing Trust Foundation

- $250,000 donation to the Affordable Housing Trust Foundation of the City of Asheville

“ The generosity demonstrated by Deerfield in making this gift is overwhelming – the residents of Deerfield are wonderful community partners. This donation will have a great impact on the City’s ability to add more affordable housing for people who need it.”

- Mayor Ester E. Manheimer

Deerfield Charitable Foundation
Mountain Area Health Education Partnership

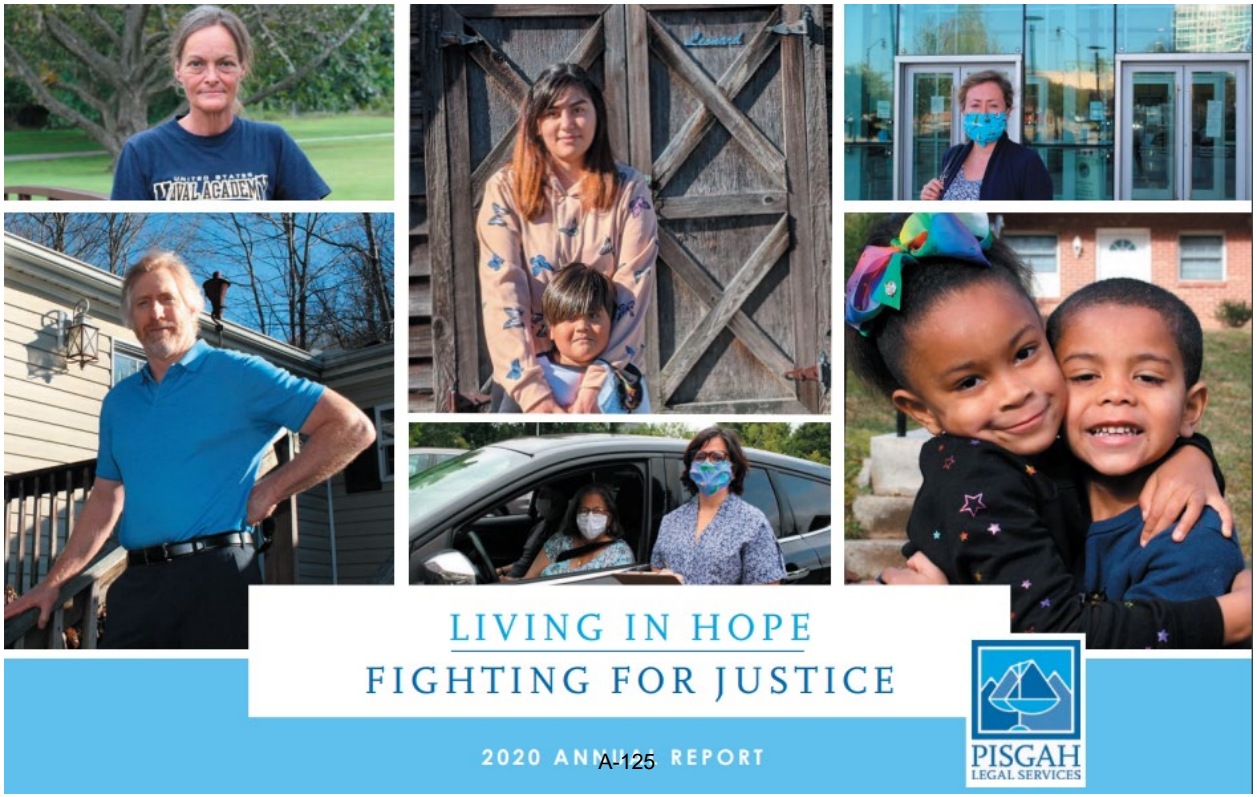
- Donation of $330,000 to the Mountain Area Health Education Center Partnership

- The practitioners provide home-based primary care to homebound low-income seniors

Deerfield Charitable Foundation
Pisgah Legal Partnership

- Donation of $104,000 to the Pisgah Legal Services Partnership

- Pisgah Legal works with clients to avoid homelessness by preventing or delaying unnecessary eviction or foreclosures and to stabilize housing for families by obtaining housing they can afford



The Project – Overview

- Deerfield is currently planning an expansion project on their campus to include:
  - 114 independent living apartments (1)
  - 26 low acuity assisted living beds
  - 13 high acuity assisted living beds
  - Parking deck
  - Renovation to the wellness center, existing common areas and expansion of the existing commons building

- Deerfield has received 313 expression of interest depositors to the project independent living apartments

- Total project related costs of approximately $200 million and construction is expected to take approximately 25 months

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The Project – Development Team

- Architect: THW Design
- Contractor: Rodgers Builders, Inc.
- Owner's Rep: B Lucas LLC
- Feasibility Consultant: Clifton Larson Allen
- CON Consultant: Dixon Hughes Goodman
- Auditor: Dixon Hughes Goodman
- Investment Banker: Ziegler
- Bond Counsel: Womble Bond Dickinson
- Corporate Counsel: McGuire Woods & Bissette
- Underwriter's Counsel: Robinson Bradshaw

The Project – Proposed Financing

- Deerfield expects to issue a mix of public fixed rate bonds and direct bank bonds for to:
  - Fund the costs of the project, including interest during construction
  - Fund issuance expenses

Sources of Funds (1)		**Uses of Funds** (1)	
2022A - Fixed Rate Bonds	$158,820,000	Project Fund	$198,573,521
2022B - Direct Bank Bonds	63,045,000	Funded Interest	20,547,103
		Costs of Issuance	2,744,376
Total Sources of Funds	**$221,865,000**	**Total Uses of Funds**	**$221,865,000**

- The table below summarizes Deerfield's pro forma debt service coverage ratio based upon the financial feasibility study work being performed by Clifton Larson Allen (1)

FYE September 30th	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**
Debt Service Coverage	3.15x	2.67x	2.81x	3.43x	4.37x	1.57x

(1) Preliminary, subject to change.

QUESTIONS & ANSWERS

EXHIBIT A/1

STATE OF NORTH CAROLINA
OFFICE OF THE GOVERNOR

ROY COOPER
GOVERNOR

February 14, 2022

Dr. Lisa A. Tolnitch
2405 Wedgedale Drive
Raleigh, North Carolina 27609

Dear Lisa:

I am pleased to appoint you to serve as a member of the North Carolina Medical Care Commission. Pursuant to N.C. Gen. Stat. § 143B-166, your appointment is effective immediately. Your term will expire on June 30, 2024.

Your board or commission is covered by the State Ethics Act. As a result, you must participate in ethics training within six months of your appointment and every two years thereafter, and you will be required to file a Statement of Economic Interest by April 15 of each year.

I am grateful for your willingness to serve the people of North Carolina. Your leadership and commitment to this Commission are key to our efforts to strengthen our communities and improve the quality of life for our people.

Please read the enclosed instructions carefully so that we may complete the appointment process. If you have any questions or need additional information, please contact the Office of Boards and Commissions at (919) 814-2077.

With kind regards, I am

Very truly yours,

Roy Cooper

cc: Secretary Kody Kinsley

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL CARE COMMISSION EMERGENCY TELECONFERENCE MEETING
DIVISION OF HEALTH SERVICE REGULATION
809 RUGGLES DRIVE, RALEIGH NC 27603
EDGERTON BUILDING
CONFERENCE ROOM - 026A
Or
Via TEAMS Video Conference: Click here to join the meeting
Or
Dial-In: 1-984-204-1487 / Passcode: 901 048 016#

Tuesday, May 3, 2022
12:30 P.M.

MINUTES

I. Meeting Attendance

MEMBERS PRESENT	MEMBERS ABSENT
John J. Meier, IV, M.D., Chairman Joseph D. Crocker, Vice-Chairman Kathy G. Barger Sally B. Cone John A. Fagg, M.D. Bryant C. Foriest Linwood B. Hollowell, III Anita L. Jackson, M.D. Eileen C. Kugler, RN, MSN, MPH, FNP Stephen T. Morton Robert E. Schaaf, M.D. Neel G. Thomas, M.D. Lisa A. Tolnitch, M.D. Jeffrey S. Wilson **DHSR STAFF** Mark Payne, Director, DHSR/Secretary, MCC Geary W. Knapp, JD, CPA, Assistant Secretary, MCC Bethany Burgon, Attorney General's Office Kimberly Randolph, Attorney General's Office Nadine Pfeiffer, Rules Review Manager, DHSR Becky Wertz, Chief, Nursing Home Licensure Beverly Speroff, Assistant Chief, Nursing Home Licensure Crystal Abbott, Auditor, MCC Alice Creech, Executive Assistant, MCC	Paul R.G. Cunningham, M.D. Ashley H. Lloyd, D.D.S. Karen E. Moriarty

OTHERS PRESENT	
Tom Akins, LeadingAge North Carolina Charles Keller, Nursing Home Badge Petitioner Adam Sholar, North Carolina Healthcare Facilities Assoc. Polly Welsh, North Carolina Healthcare Facilities Assoc. Ben Popkin, Popkin Strategies	

II. Chairman's Comments.....Dr. John Meier

III. Public Meeting Statement.....Dr. John Meier

This meeting of the Medical Care Commission is open to the public but is not a public hearing. Therefore, any discussion will be limited to members of the Commission and staff unless questions are specifically directed by the Commission to someone in the audience.

IV. Ethics Statement.....Dr. John Meier

The State Government Ethics Act requires members to act in the best interest of the public and adhere to the ethical standards and rules of conduct in the State Government Ethics Act, including the duty to continually monitor, evaluate, and manage personal, financial, and professional affairs to ensure the absence of conflicts of interest.

V. New Business

A. Petition for Rulemaking (Approve or deny petition received)

1. Petition for rulemaking for Nursing Home name badges.....N. Pfeiffer & B. Speroff **(See Exhibits A-A/1)**

COMMISSION ACTION: *A motion was made by Mrs. Eileen Kugler to deny the Nursing Home Badge petition as written, seconded by Dr. John Fagg, and unanimously approved.*

COMMISSION ACTION: *A motion was made by Mrs. Eileen Kugler for the agency to evaluate the need for such a rule for nursing home identification badges with requirements designed to achieve regulatory objective in a cost effective manner that reduces the burden upon those persons who must comply with the rule requirements, seconded by Mr. Bryant Foriest, and approved with the disapproval of Mr. Joe Crocker.*

VI. Meeting Adjournment

There being no further business the meeting was adjourned at 1:35 p.m.

Respectfully Submitted,

Geary W. Knapp, Assistant Secretary

Payne, Mark

From: Charles Keller <charles.w.keller@gmail.com>
Sent: Tuesday, January 11, 2022 1:09 PM
To: Payne, Mark
Subject: [External] Rule Making Proposal RE: Name Badges

January 11, 2022
Office of the Director

Division of Health Service Regulation

2701 Mail Service Center

Raleigh, North Carolina, 27699-2701

DELIVERED VIA EMAIL (Mark.Payne@dhhs.nc.gov)

Dear Mr. Payne:

Please accept this correspondence at my petition for rulemaking pursuant to G.S. 150B-20. The reason I present this petition is because seniors in nursing facilities and their advocates have difficulty obtaining identification of the person providing them care. Names are often forgotten, misheard, nicknames or aliases are provided, staff claim not to know the name of their coworkers, some nursing facility management has instructed staff to only provide a first name, and then flatly refuse to give it when asked directly. Not knowing the accurate name of a caregiver presents an issue of patient safety because complaints regarding care cannot be expeditiously addressed, reports to regulatory agencies lack vital identifying information, family and patients have no way to verify professional licensure is in good standing (for example NC LPN licensure look up requires a first and last name to search), or privately run a criminal records check on staff that may only had a check years earlier upon being hired. The dignity of the patent is violated when they have no way to meaningfully identify a person who provides them care.

This rule, if enacted, will promote professionalism in an industry that holds great power over their frail and elderly customers. It will protect this population from nursing home malfeasance and benign neglect. A savvy, wealthy senior, whose cognitive abilities can obtain a copy of their records and sometimes glean the name of some staff from their records, but not everyone knows to make the request and the facility charges for the copy.

This rule petition has no effect on existing rules or orders.

An internet search of name badge suppliers indicates the cost of the badge is anywhere between $2.00 and $10.00. Given that most nursing facilities charge at least between $191.79 per day, per resident as of July 1, 2021,[1] this is a small cost in comparison to the public benefit.

Currently, Georgia, Minnesota, Oregon, New York, California, Illinois, Massachusetts and Rhode Island have identification badge laws. North Carolina should join these states in vigorously giving vulnerable senior citizens the maximum protection possible.

Proposed Rule Text

10 NCAC 13D .XXXX Identification Badges

All nursing facilities shall issue name badges that conspicuously display the full legal name, nickname and the licensure, if applicable, in 18 point font for every staff member, contractor or volunteer that examines patients, provides treatment or care to patients, and gives custodial care to a patient. The badge must be prominently displayed on the staff member, contractor or volunteer's person at all times.

The name of any staff member, contractor or volunteer must be immediately provided in writing upon the request of a patient, visitor or family member of a patient within twenty-four hours of the request being made.

History Note: Authority: G.S. 131E-104; G.S. 131E-117(1); G.S. 131E-117(5); G.S. 131E-117(6); G.S. 131E-131;
Effective Date: April 1, 2022.

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[1] https://medicaid.ncdhhs.gov/providers/fee-schedules/nursing-facility-fee-schedules

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Thank you for your time and consideration,

Charles Keller, Jr.

"I will find a way or make one!"

NH Name Badge Petition for Proposed Rule
Agency Recommendation

The Agency supports the idea and intent of the rule proposed in this petition; however, the Agency recommends denial of the petition based upon G.S. 150B-19.1 (a)(2) and (6). In lieu of granting the petition, the Agency recommends evaluating the need for such a rule for identification badges with requirements designed to achieve the regulatory objective in a cost-effective manner and reduced burden upon those persons or entities who must comply with the rule.

G.S. 90-640 requires licensed, certified, or registered health care practitioners to wear identification badges and does not include this requirement for unlicensed direct care and indirect care staff employed in a facility.

The North Carolina Health Care Facilities Association and Leading Age North Carolina stated that many skilled nursing facilities already use identification badges with all staff, licensed and unlicensed.

The Agency proposes evaluating the potential need to develop such a rule that would allow the preservation of the badges that are already in use so long as the badges in use can achieve the regulatory objective of proper identification of the staff at the facilities. This proposal could allow the facilities to use the resources that already exist instead of having to devote time and resources to comply with new specifications for identification badges during an on-going pandemic.

NC Medical Care Commission

Quarterly Report on **Outstanding Debt** (End: 3rd Quarter FYE 2022)

Program Measures	FYE 2021 Ending: 6/30/2021	FYE 2022 Ending: 3/31/2022
Outstanding Debt	**$5,458,749,746**	**$5,121,713,116**
Outstanding Series	**126**[1]	**121**[1]

Detail of Program Measures	Ending: 6/30/2021	Ending: 3/31/2022
Outstanding Debt per Hospitals and Healthcare Systems	$3,987,631,982	$3,620,293,931
Outstanding Debt per CCRCs	$1,416,747,763	$1,501,419,185
Outstanding Debt per Other Healthcare Service Providers	$54,370,000	$0
Outstanding Debt Total	**$5,458,749,746**	**$5,121,713,116**
Outstanding Series per Hospitals and Healthcare Systems	68	63
Outstanding Series per CCRCs	56	58
Outstanding Series per Other Healthcare Service Providers	2	0
Series Total	**126**	**121**
Number of Hospitals and Healthcare Systems with Outstanding Debt	14	12
Number of CCRCs with Outstanding Debt	17	18
Number of Other Healthcare Service Providers with Outstanding Debt	1	0
Facility Total	32	30

Exhibit B (Outstanding Balance)

Note 1: For FYE 2022, NCMCC has closed 26 **Bond Series**. Out of the closed Bond Series: 11 were conversions, 6 were new money projects, 1 combination of new money project and refunding, and 8 were refundings. The Bond Series outstanding from FYE 2021 to current represents all new money projects, refundings, conversions, and redemptions.

GENERAL NOTES: Facility Totals represent a parent entity total and do not represent each individual facility owned/managed by the parent entity. CCRCs are licensed by the NC Department of Insurance. "Other Healthcare Service Providers" would include nursing homes, rehabilitation facilities, assisted living, blood donation centers, and hospice facilities. The following parent entities represent the current "other healthcare service providers" with outstanding NC MCC debt: NONE AT THIS TIME

NC Medical Care Commission

Quarterly Report on **History** of NC MCC Finance Act Program (End: 3rd Quarter FYE 2022)

Program Measures	FYE 2021 Ending: 6/30/2021	FYE 2022 Ending: 3/31/2022
Total PAR Amount of Debt Issued	**$27,586,164,692**	**$28,520,984,976**
Total Project Debt Issued (excludes refunding/conversion proceeds) [1]	**$13,433,214,540**	**$13,534,564,090**
Total Series Issued	**665**	**691**

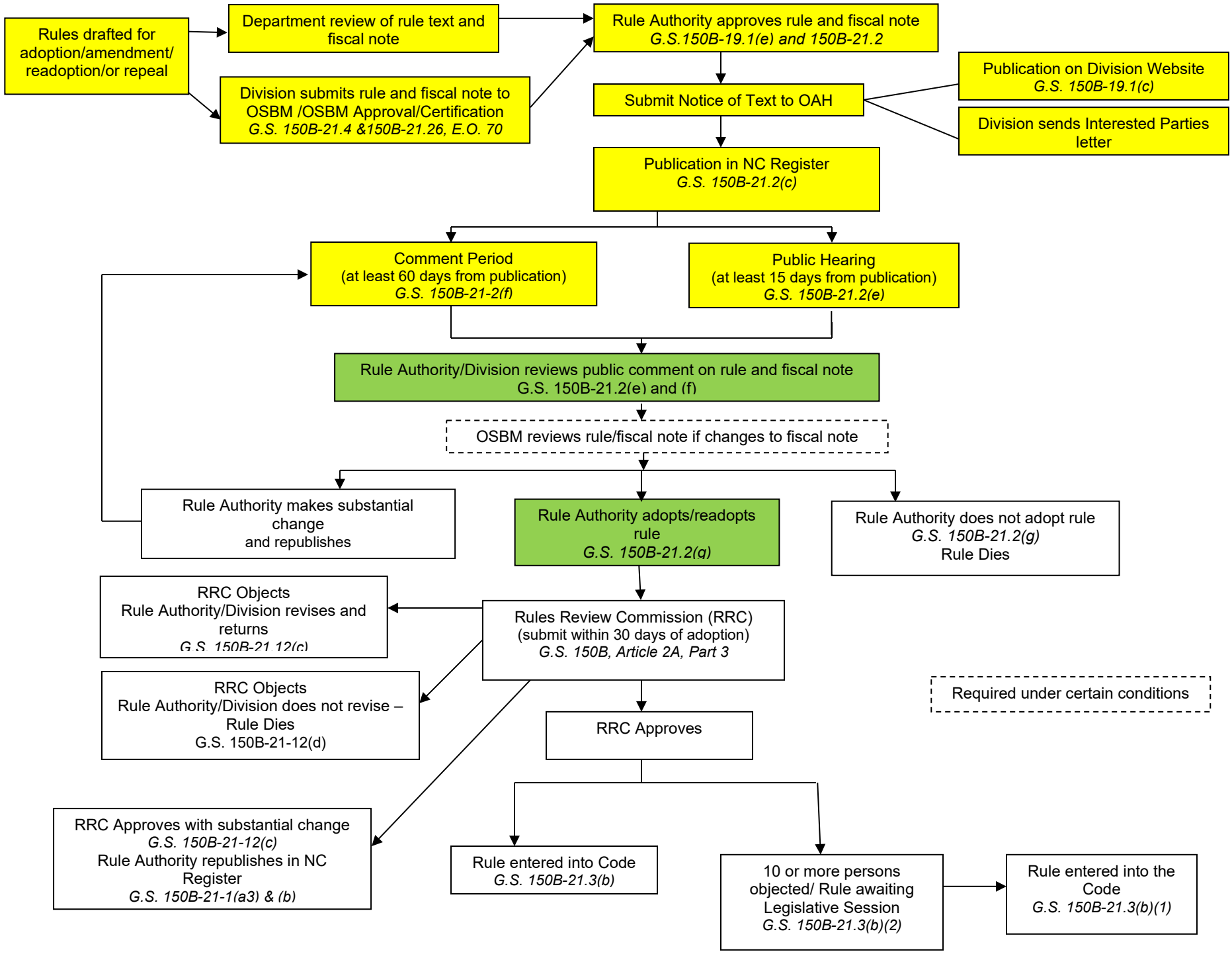
Detail of Program Measures	Ending: 6/30/2021	Ending: 3/31/2022
PAR Amount of Debt per Hospitals and Healthcare Systems	$22,123,409,855	$22,719,889,855
PAR Amount of Debt per CCRCs	$5,088,459,607	$5,426,799,890
PAR Amount of Debt per Other Healthcare Service Providers	$374,295,230	$374,295,230
Par Amount Total	**$27,586,164,692**	**$28,520,984,976**
Project Debt per Hospitals and Healthcare Systems	$10,273,019,674	$10,273,019,674
Project Debt per CCRCs	$2,913,180,952	$3,014,530,502
Project Debt per Other Healthcare Service Providers	$247,013,915	$247,013,915
Project Debt Total	**$13,433,214,540**	**$13,534,564,090**
Series per Hospitals and Healthcare Systems	414	425
Series per CCRCs	212	227
Series per Other Healthcare Service Providers	39	39
Series Total	**665**	**691**
Number of Hospitals and Healthcare Systems issuing debt	99	99
Number of CCRCs issuing debt	40	41
Number of Other Healthcare Service Providers issuing debt	46	46
Facility Total	185	186

Note 1: Project Debt excludes bond proceeds that directly refunded prior NCMCC outstanding issues and conversion par amounts. Project Debt is an accumulation of all new project money, issuance costs (including issuance costs for refundings/conversions (if any)), and refundings of non-NCMCC debt.

GENERAL NOTES: Facility Totals represent each individual facility and do not represent parent entity totals. CCRCs are licensed by the NC Department of Insurance. "Other Healthcare Service Providers" would include nursing homes, rehabilitation facilities, assisted living, blood donation centers, and hospice facilities.

Process for Medical Care Commission to Adopt/Readopt Rule

Exhibit C



10A NCAC 13B .3801 is readopted as published in 36:12 NCR 1029-1032 as follows:

SECTION .3800 - NURSING SERVICES

10A NCAC 13B .3801 NURSE EXECUTIVE

(a) Whether the facility utilizes a centralized or decentralized organizational structure, a nurse executive shall be responsible for the coordination of nursing organizational functions.

(b) A nurse executive shall develop facility wide patient care programs, ~~policies~~ policies, and procedures that describe how the nursing care needs of patients are assessed, ~~met~~ met, and evaluated.

(c) The nurse executive shall develop and adopt, subject to the approval of the facility, a set of administrative policies and procedures to establish a framework to accomplish required functions.

(d) There shall be scheduled ~~meetings,~~ meetings ~~at least~~ every 60 ~~days,~~ days of the members of the nursing staff to evaluate the quality and efficiency of nursing services. Minutes of these meetings shall be maintained.

(e) The nurse executive shall be responsible for:

(1) the development of a written organizational plan which describes the levels of accountability and responsibility within the nursing organization;

(2) identification of standards and policies and procedures related to the delivery of nursing care;

(3) planning for and the evaluation of the delivery of nursing care delivery system;

(4) establishment of a mechanism to validate qualifications, knowledge, and skills of nursing personnel;

(5) provision of orientation and educational opportunities related to expected nursing ~~performance,~~ performance and maintenance of records pertaining thereto;

(6) implementation of a system for performance evaluation;

(7) provision of nursing care services in conformance with ~~the North Carolina Nursing Practice Act;~~ G.S. 90-171.20(7) and G.S. 90-171.20(8);

(8) assignment of nursing staff to clinical or managerial responsibilities based upon educational preparation, in conformance with licensing laws and an assessment of current competence; and

(9) staffing nursing units with ~~sufficient~~ personnel in accordance with a written ~~plan.~~ plan of care to meet the needs of the patients.

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .3903 is readopted as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .3903 PRESERVATION OF MEDICAL RECORDS

(a) The manager of medical records service shall maintain medical records, whether original, computer media, or microfilm, for ~~a minimum of~~ 11 years following the discharge of an adult patient.

(b) The manager of medical records shall maintain medical records of a patient who is a minor until the patient's 30th birthday.

(c) If a hospital discontinues operation, its management shall make known to the Division where its records are stored. Records shall be stored in a business offering retrieval services for ~~at least~~ 11 years after the closure date.

~~(d) The hospital shall give public notice prior to destruction of its records, to permit former patients or representatives of former patients to claim the record of the former patient. Public notice shall be in at least two forms: written notice to the former patient or their representative and display of an advertisement in a newspaper of general circulation in the area of the facility.~~

~~(e)~~(d) The manager of medical records may authorize the microfilming of medical records. Microfilming may be done on or off the premises. If done off the premises, the facility shall provide for the confidentiality and safekeeping of the records. The original of microfilmed medical records shall not be destroyed until the medical records department has had an opportunity to review the processed film for content.

~~(f)~~(e) Nothing in this Section shall be construed to prohibit the use of automation in the medical records service, provided that all of the provisions in this Rule are met and the information is readily available for use in patient care.

~~(g)~~(f) Only personnel authorized by ~~state~~ State laws and Health Insurance Portability and Accountability Act (HIPAA) regulations shall have access to medical records. Where the written authorization of a patient is required for the release or disclosure of health information, the written authorization of the patient or authorized representative shall be maintained in the original record as authority for the release or disclosure.

~~(h)~~(g) Medical records are the property of the hospital, and they shall not be removed from the facility jurisdiction except through a court order. Copies shall be made available for authorized purposes such as insurance claims and physician review.

History Note: *Authority G.S. ~~90-21.20B;~~ 131E-75(b); 131E-79; 131E-97;*
Eff. January 1, 1996;
Amended Eff. July 1, ~~2009.~~ 2009;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4103 is readopted as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .4103 PROVISION OF EMERGENCY SERVICES

(a) Any ~~of any~~ facility providing emergency services shall establish and maintain policies requiring ~~appropriate~~ medical screening, treatment and transfer services for any individual who presents to the facility emergency department and on whose behalf treatment is requested regardless of that person's ability to pay for medical services and without delay to inquire about the individual's method of payment.

(b) Any facility providing emergency services under the rules of this Section shall install, ~~operate~~ operate, and maintain, on a 24-hour per day basis, an emergency two-way radio ~~licensed by the Federal Communications Commission in the Public Safety Radio Service~~ capable of ~~establishing~~ accessing the North Carolina Voice Interoperability Plan for Emergency Responders (VIPER) radio network for voice ~~radio~~ communication with ~~ambulance units~~ EMS providers transporting patients to ~~said~~ the facility or ~~having any written procedure or agreement for handling emergency services with the local ambulance service, rescue squad or other trained medical~~ or provide on-line medical direction for EMS personnel.

(c) All communication equipment shall be in compliance with ~~current~~ the rules ~~established by North Carolina Rules for Basic Life Support/Ambulance Service (10 NCAC 3D .1100) adopted by reference with all subsequent amendments. Referenced rules are available at no charge from the Office of Emergency Medical Services, 2707 Mail Service Center, Raleigh, N.C. 27699-2707.~~ set forth in 10A NCAC 13P, Emergency Medical Services and Trauma Rules.

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4104 is readopted as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .4104 MEDICAL DIRECTOR

(a) The governing body shall establish the qualifications, duties, and authority of the director of emergency services. Appointments shall be recommended by the medical staff and approved by the governing body.

(b) The medical staff credentials committee shall approve the mechanism for emergency privileges for physicians employed for brief periods of time such as evenings, ~~weekends~~ weekends, or holidays.

(c) Level I and II emergency services shall be directed and supervised by a ~~physician with experience in emergency care.~~ physician.

(d) Level III services shall be directed and supervised by a ~~physician with experience in emergency care or through a multi-disciplinary medical staff committee. The chairman of this committee shall serve as director of emergency medical services.~~ physician.

History Note: *Authority G.S. 131E-75(b); 131E-79; 131E-85(a);*
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4106 is readopted as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .4106 POLICIES AND PROCEDURES

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

(1) the location, storage, and procurement of medications, blood, supplies, equipment and the procedures to be followed in the event of equipment failure;

(2) the initial management of patients with burns, hand injuries, head injuries, fractures, multiple injuries, poisoning, animal bites, gunshot or stab ~~wounds~~ wounds, and other acute problems;

(3) the provision of care to an unemancipated minor not accompanied by a parent or guardian, or to an unaccompanied unconscious patient;

(4) management of alleged or suspected child, ~~elder~~ elder, or adult abuse;

(5) the management of pediatric emergencies;

(6) the initial management of patients with actual or suspected exposure to radiation;

(7) management of alleged or suspected rape victims;

(8) the reporting of individuals dead on arrival to the proper authorities;

(9) the use of standing orders;

(10) tetanus and rabies prevention or prophylaxis; and

(11) the dispensing of medications in accordance with ~~state~~ State and federal laws.

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4305 is readopted as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .4305 ORGANIZATION OF NEONATAL SERVICES

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

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

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

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

(4) LEVEL IV (Neonatal Intensive Care Services): High-risk, medically unstable or critically ill neonates approximately under 32 weeks of gestational age, or infants, requiring constant nursing care or supervision ~~not limited to~~ that includes continuous cardiopulmonary or respiratory support, complicated surgical procedures, or other intensive supportive interventions.

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

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

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, 1996;
Temporary Amendment Eff. March 15, 2002;
Amended Eff. April 1, ~~2003.~~ 2003;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4603 is readopted as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .4603 SURGICAL AND ANESTHESIA STAFF

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

~~(b) The facility shall require that:~~

(1) when anesthesia is administered, a ~~qualified~~ physician is ~~immediately~~ available in the facility to provide care in the event of a medical emergency;

(2) a roster of practitioners with a delineation of current surgical and anesthesia privileges is available and maintained for the service;

(3) an on-call schedule of surgeons with privileges to be available at all times for emergency surgery and for post-operative clinical management is maintained;

(4) the operating room is supervised by a ~~qualified~~ registered nurse or doctor of medicine or osteopathy; and

(5) an operating room register which shall include date of the operation, name and patient identification number, names of surgeons and surgical assistants, name of anesthetists, type of anesthesia given, pre- and post-operative diagnosis, type and duration of surgical procedure, and the presence or absence of complications in surgery is maintained.

History Note: *Authority G.S. 131E-75(b); 131E-79; 131E-85;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4801 is readopted as published in 36:12 NCR 1029-1032 as follows:

SECTION .4800 - DIAGNOSTIC IMAGING

10A NCAC 13B .4801 ORGANIZATION

(a) Imaging services shall be under the supervision of a full-time radiologist, consulting radiologist, or a ~~physician~~ physician. ~~experienced in the particular imaging modality and the~~ The physician in charge ~~must~~ shall have the credentials required by facility policies.

(b) ~~Activities of the imaging service may include radio-therapy.~~ Radio-therapy is a type of imaging service.

(c) All imaging equipment shall be operated under professional supervision by ~~qualified~~ personnel trained in the use of imaging equipment and knowledgeable of all applicable safety precautions required by the North Carolina Department of ~~Environment and Natural Resources,~~ Health and Human Services, Division of ~~Environmental~~ Health Service Regulation, Radiation Protection ~~Section.~~ Section set forth in 10A NCAC 15, hereby incorporated by reference including subsequent amendments. ~~Copies of regulations are available from the N.C. Department of Environment and Natural Resources, Radiation Protection Section, 3825 Barrett Drive, Raleigh, NC 27609 at a cost of sixteen dollars ($16.00) each~~.

History Note: *Authority G.S. 131E-75(b); 131E-79;*
RRC objection due to lack of statutory authority and ambiguity Eff. July 13, 1995;
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4805 is readopted as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .4805 SAFETY

(a) The facility shall require that all imaging equipment is operated under the supervision of a physician and by qualified personnel.

(b) The facility shall require that proper caution is exercised to protect all persons from exposure to radiation.

(c) Safety inspections of the imaging department, including equipment, shall be conducted by the North Carolina Division of ~~Environmental Health,~~ Health Service Regulation, Radiation Protection ~~Services~~ Section. Copies of the report shall be available for review by the Division.

(d) The governing authority shall appoint a radiation safety committee. The committee shall ~~include but is not limited to:~~ include:

(1) a physician experienced in the handling of radio-active isotopes and their therapeutic use; and

(2) other representatives of the medical staff.

(e) All radio-active isotopes, whether for diagnostic, therapeutic, or research purposes shall be received, handled, and disposed of in accordance with the requirements of the North Carolina Department of ~~Environment and Natural Resources,~~ Health and Human Services, Division of ~~Environmental Health,~~ Health Service Regulation, Radiation Protection ~~Services Section.~~ Section set forth in 10A NCAC 15, hereby incorporated by reference including subsequent amendments. ~~Copies of regulations are available from the North Carolina Department of Environment, Health, and Natural Resources, Division of Radiation Protection, 3825 Barrett Drive, Raleigh, NC 27609 at a cost of six dollars ($6.00) each.~~

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .5102 is readopted as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .5102 POLICY AND PROCEDURES

(a) Each facility department or service shall establish and maintain written infection control policies and procedures. These shall ~~include but are not limited to:~~ include:

(1) the role and scope of the service or department in the infection control program;

(2) the role and scope of surveillance activities in the infection control program;

(3) the methodology used to collect and analyze data, maintain a surveillance program on nosocomial infection, and the control and prevention of infection;

(4) the specific precautions to be used to prevent the transmission of infection and isolation methods to be utilized;

(5) the method of sterilization and storage of equipment and supplies, including the reprocessing of disposable items;

(6) the cleaning of patient care areas and equipment;

(7) the cleaning of non-patient care areas; and

(8) exposure control plans.

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

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

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff July 1, 2022.

10A NCAC 13B .5105 is readopted as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .5105 STERILE SUPPLY SERVICES

The facility shall provide for the following:

(1) decontamination and sterilization of equipment and supplies;

(2) monitoring of sterilizing equipment on a routine schedule;

(3) establishment of policies and procedures for the use of disposable items; and

(4) establishment of policies and procedures addressing shelf life of stored sterile items.

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .5406 is readopted as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .5406 DISCHARGE CRITERIA FOR INPATIENT REHABILITATION FACILITIES OR UNITS

(a) Discharge planning shall be an integral part of the patient's treatment plan and shall begin upon admission to the facility. After established goals have been reached, or a determination has been made that care in a less intensive setting would be appropriate, or that further progress is unlikely, the patient shall be discharged to an appropriate setting. Other reasons for discharge may include an inability or unwillingness of patient or family to cooperate with the planned therapeutic program or medical complications that preclude a further intensive rehabilitative effort. The facility shall involve the patient, family, staff ~~members~~ members, and referral sources in discharge planning.

(b) The case manager shall facilitate the discharge or transfer process in coordination with the facility social worker.

(c) If a patient is being referred to another facility for further care, ~~appropriate~~ documentation of the patient's current status shall be forwarded with the patient. A ~~formal~~ discharge summary shall be forwarded within 48 hours following discharge and shall include the reasons for referral, the diagnosis, functional limitations, services provided, the results of services, referral action ~~recommendations~~ recommendations, and activities and procedures used by the patient to maintain and improve functioning.

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. March 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .5408 is readopted as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .5408 COMPREHENSIVE INPATIENT REHABILITATION PROGRAM STAFFING REQUIREMENTS

(a) The staff of the inpatient rehabilitation facility or unit shall ~~include at a minimum:~~ include:

(1) the inpatient rehabilitation facility or unit shall be supervised by a rehabilitation ~~nurse.~~ nurse as defined in Rule .5401 of this Section. The facility shall ~~identify the nursing skills necessary to meet the needs of the rehabilitation patients in the unit and~~ assign staff qualified to meet those needs;

(2) the minimum nursing hours per patient in the rehabilitation unit shall be 5.5 nursing hours per patient day. At no time shall direct care nursing staff be less than two full-time equivalents, one of which must be a registered nurse;

(3) the inpatient rehabilitation unit shall employ or provide by contractual agreements ~~sufficient~~ therapist to provide ~~a minimum of~~ three hours of specific (physical, occupational or speech) or combined rehabilitation therapy services per patient day;

(4) physical therapy assistants and occupational therapy assistants shall be supervised on-site by physical therapists or occupational therapists;

(5) rehabilitation aides shall have documented training appropriate to the activities to be performed and the occupational licensure laws of his or her supervisor. The overall responsibility for the on-going supervision and evaluation of the rehabilitation aide remains with the registered nurse as identified in Subparagraph (a)(1) of this Rule. Supervision by the physical therapist or by the occupational therapist is limited to that time when the therapist is on-site and directing the rehabilitation activities of the aide; and

(6) hours of service by the rehabilitation aide are counted toward the required nursing hours when the aide is working under the supervision of the nurse. Hours of service by the rehabilitation aide are counted toward therapy hours during that time the aide works under the immediate, on-site supervision of the physical therapist or occupational therapist. Hours of service shall not be dually counted for both services. Hours of service by rehabilitation aides in performing nurse-aide duties in areas of the facility other than the rehabilitation unit shall not be counted toward the 5.5 hour minimum nursing requirement described for the rehabilitation unit.

(b) Additional personnel shall be provided as required to meet the needs of the patient, as defined in the comprehensive inpatient rehabilitation evaluation.

History Note: *Authority G.S. 131E-75(b);131E-79;*
RRC Objection due to lack of statutory authority Eff. January 18, 1996;
Eff. May 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .5411 is repealed through readoption as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .5411 PHYSICAL FACILITY REQUIREMENTS/INPATIENT REHABILITATION FACILITIES OR UNIT

History Note: *Authority G.S. 131E-79;*
Eff. March 1, ~~1996.~~ 1996;
Repealed Eff. July 1, 2022.

Fiscal Impact Analysis of Permanent Rule Readoption without Substantial Economic Impact

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Agency:	North Carolina Medical Care Commission Division of Health Service Regulation Acute Care Licensure and Certification Section

Rule Citation(s):

10A NCAC 13B .3801 Nurse Executive
10A NCAC 13B .3903 Preservation of Medical Records
10A NCAC 13B .4103 Provision of Emergency Services
10A NCAC 13B .4104 Medical Director
10A NCAC 13B .4106 Policies and Procedures
10A NCAC 13B .4305 Organization of Neonatal Services
10A NCAC 13B .4603 Surgical and Anesthesia Staff
10A NCAC 13B .4801 Organization
10A NCAC 13B .4805 Safety
10A NCAC 13B .5102 Policy and Procedures
10A NCAC 13B .5105 Sterile Supply Services
10A NCAC 13B .5406 Discharge Criteria for Inpatient Rehabilitation Facilities or Units
10A NCAC 13B .5408 Comprehensive Inpatient Rehabilitation Program Staffing Requirements
10A NCAC 13B .5411 Physical Facility Requirements/Inpatient Rehabilitation Facilities or Unit
(see rule text in Appendix A)

Agency Contact:	Nadine Pfeiffer, DHSR Rules Review Manager – 919-855-3811 Azzie Conley, Section Chief, Acute and Home Care Licensure & Certification – 919-855-4646 Greta Hill, Assistant Section Chief, Acute and Home Care Licensure & Certification – 919-855-4635
Rulemaking Authority:	G.S. 131E-75(b); 131E-79;

Impact Summary:	State Government:	No Impact
	Local Government:	No Impact
	Private Entities:	Impact
	Substantial Impact:	No Impact

Introduction and Purpose

Under authority of G.S. 150B-21-3A, Periodic Review and Expiration of Existing Rules, the Medical Care Commission, Rules Review Commission, and the Joint Legislative Administrative Procedure Oversight Committee approved the Subchapter report with classifications for the rules located at 10A NCAC 13B -– Rules for the Licensing of Hospitals on February 10, 2017, May 18, 2017, and July 22, 2017 respectively. As a result of the periodic review of rules, 40 rules were determined as "Necessary With Substantive Public Interest," requiring readoption as new rules for this Subchapter. As of July 1, 2021, three phases totaling 26 rules have been readopted by the N.C. Medical Care Commission (MCC), thereby leaving 14 rules for readoption.

There are 120 licensed Hospitals in North Carolina. This fiscal analysis addresses the fourth phase with the remaining 14 rules for readoption following the periodic review of rules. Fives rules were revised with substantive changes to update practices and language, address previous Rule Review Committee objections, provide clarity, remove ambiguity, and implement technical changes. The changes will also allow reference to the General Statute. (Rules (10A NCAC 13B, .3801, .3903, .4103, .4104, and .5408).

Eight rules were revised without substantive changes (Rules 10A NCAC 13B .4106, .4305, .4603, .4801, .4805, .5102, .5105, .5406) and one rule is being repealed (Rule 10A NCAC 13B .5411). Per statute, these rules are not subject to a fiscal analysis therefore a discussion of these rules is not included in the document.

Description of Proposed Rules and Anticipated Fiscal Impact

Rule 10A NCAC 13B .3801- Nurse Executive

The agency is proposing to readopt this rule with substantive changes. This rule establishes the criteria for the assignment of nursing staff for the provision of care according to a written plan. Changes clarify that the written plan is the plan of care that reflects the patient's goals and the nursing care to be provided to meet the patient's needs. The Nurse Executive must ensure that there are adequate numbers of clinical nursing personnel with the appropriate education, experience, licensure, competence, and specialized qualifications to provide nursing care for each patient in accordance with the individual needs of each patient specified in the plan of care. Adding this language will have no additional impact on the role of the Nurse Executive as this is a federal requirement under CMS regulations to receive federal funding and represents current practice. There is no fiscal impact associated with the amendment of this rule.

In addition, the agency referenced the General Statute for the practice of nursing services. Referencing the statute does not change or expand the scope of the nursing care services, it just clarifies the specific statutes that are applicable to the practice of nursing.

Rule 10A NCAC 13B .3903 - Preservation of Medical Records

The agency is proposing to amend this rule. This rule establishes the criteria for the preservation of medical records. Currently, the rule requires public notice to be given when a hospital is going to destroy medical records after the 11 year storage period in at least a written notice to the former patient or their representative and the display of an advertisement in a newspaper of general circulation in the area of the facility. The agency is updating the rule to not require patient notification before the destruction of the medical records. A review of other states' regulations in this space span from no regulations at all to a thirty year record retention policy.[1] In general, two other states have similar rules that require notification before destruction of medical records by hospitals (North Dakota and Pennsylvania) but most states do not require this notification. In addition to being in the minority of states with notification rules, requiring printed notice in the newspaper no longer makes sense as printed newspapers have dropped significantly in circulation and availability. Not requiring printed notice to either patients or their representatives and not requiring an advertisement to be printed in the newspaper will most likely save the hospital money.

[1] Protecting Patient Information after a Facility Closure. Appendix C: States with Laws, Regulations, or Guidelines Pertaining to Facility Closure. Accessed 9/27/2021. https://library.ahima.org/doc?oid=105007#.YUzI2zUpBhF

The amount of money saved would be dependent upon the cost of the newspaper advertisement which differs between localities and also the number of patients they were required to notify in written form.

The loss of the notification requirement may increase the likelihood that a patient is unable to access their old medical records if they are not informed about the facility disposing of their records. However, it is unknown how many patients this rule change will impact as well as what the actual consequences of not being able to access medical records that are over a decade old would be. Overall, this rule change likely represents a cost savings to facilities.

Rule 10A NCAC 13B .4103 - Provision of Emergency Services

The agency is proposing to readopt this rule with substantive changes. This rule establishes the criteria for the provision of emergency services and requirements for interoperable communication. This rule is being changed to update the interoperable communication system to the North Carolina Voice Interoperability Plan for Emergency Responder (NC VIPER). All hospitals, with emergency departments, that receive patients from EMS, have access to the VIPER system. Each facility has been assigned an exclusive talk group (channel) to communicate with EMS units. All radios operating on the VIPER system are required to have the minimum statewide template installed. The template provides the facility with interoperability channels to communicate with public safety agencies and also the NC Emergency Management 24-hour Watch Center in the event of a disaster, terrorist event or total loss of traditional communications means (internet, telephone, cell phone).

The VIPER system is almost completely built out, and offers +95% statewide coverage, from the mobile level. The original VIPER radios were provided to all of the hospitals through a federal grant, passed through the Healthcare Preparedness Program (HPP) approximately 12-15 years ago. The radios became the property of the facility and it has been their responsibility for the maintenance and upgrades. The VIPER system is scheduled for a system upgrade to P25 phase II (TDMA) in 2025. The original radios are not capable of this upgrade and the facilities will need to replace them by that target date. OEMS has been pushing out information to the facilities since July 2019, on this required system upgrade. Many facilities have already completed the replacement of their VIPER units. The rule already requires operators to install, operate, and maintain their radios – this rule change simply updates the rule to reflect the current technology that is already being used by operators. There is no fiscal impact associated with the readoption of this rule.

Changes were also made to update language to current terminology, update reference to reflect rule recodification change, and included other technical changes.

Rule 10A NCAC 13B .4104 - Medical Director

The agency is proposing to readopt this rule with substantive changes. This rule establishes both the qualifications of the physician directing Level I, II, and III emergency services and the criteria for the duties and authority of the Medical Director/Director of Emergency Services. This rule is being updated to reflect a historical Rules Review Commission objection that determined the agency has no authority for regulating the qualifications of the director of emergency services.

The hospital's medical staff establishes the criteria for the qualifications for the director of the hospital's emergency services in accordance with State law and acceptable standards of practice. The qualifications include necessary education, experience, and specialized training. This is a federal requirement under CMS regulations to receive federal funding.

The proposed change removes the requirement for the director of emergency medical services to serve as chairman of the medical staff committee. The medical staff also establishes the criteria and delineates the qualifications a medical staff member must possess, in order to be granted privileges for the supervision of the provision of emergency care services and to serve as chairman of the medical staff committee. This is a federal requirement. There is no fiscal impact associated with the readoption of this rule.

Rule 10A NCAC 13B .5408 - Comprehensive Inpatient Rehabilitation Program Staffing Requirements

This rule establishes the inpatient rehabilitation program staffing requirements. The agency is proposing to readopt this rule with substantive changes. An historical Rules Review Commission Objection determined that the rule is confusing, and the agency lacked statutory authority to set staff qualification requirements. Revisions to the rule have satisfied this objection and technical changes were made. These rule changes should not result in any changes in practice and simply provide clarity to the rule's language.

There is no fiscal impact associated with the amendment of this rule.

Impact Summary

These readoptions update rules to account for current practices and language, remove ambiguity, address historical Rule Review Commission objections, and implement technical changes. Changes also allow reference to the General Statute where appropriate. The rule change that is likely to have the largest impact is Rule 10A NCAC 1B .3903 – Preservation of Medical Records. It will likely result in an unknown cost savings to the facility. The other rules are unlikely to have any fiscal impact.

Appendix A

10A NCAC 13B .3801 is proposed for readoption with substantive changes as follows:

SECTION .3800 - NURSING SERVICES

10A NCAC 13B .3801 NURSE EXECUTIVE

(a) Whether the facility utilizes a centralized or decentralized organizational structure, a nurse executive shall be responsible for the coordination of nursing organizational functions.

(b) A nurse executive shall develop facility wide patient care programs, ~~policies~~ policies, and procedures that describe how the nursing care needs of patients are assessed, ~~met~~ met, and evaluated.

(c) The nurse executive shall develop and adopt, subject to the approval of the facility, a set of administrative policies and procedures to establish a framework to accomplish required functions.

(d) There shall be scheduled ~~meetings,~~ meetings ~~at least~~ every 60 ~~days,~~ days of the members of the nursing staff to evaluate the quality and efficiency of nursing services. Minutes of these meetings shall be maintained.

(e) The nurse executive shall be responsible for:

(1) the development of a written organizational plan which describes the levels of accountability and responsibility within the nursing organization;

(2) identification of standards and policies and procedures related to the delivery of nursing care;

(3) planning for and the evaluation of the delivery of nursing care delivery system;

(4) establishment of a mechanism to validate qualifications, knowledge, and skills of nursing personnel;

(5) provision of orientation and educational opportunities related to expected nursing ~~performance,~~ performance and maintenance of records pertaining thereto;

(6) implementation of a system for performance evaluation;

(7) provision of nursing care services in conformance with ~~the North Carolina Nursing Practice Act;~~ G.S. 90-171.20(7) and G.S. 90-171.20(8);

(8) assignment of nursing staff to clinical or managerial responsibilities based upon educational preparation, in conformance with licensing laws and an assessment of current competence; and

(9) staffing nursing units with ~~sufficient~~ personnel in accordance with a written ~~plan.~~ plan of care to meet the needs of the patients.

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .3903 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .3903 PRESERVATION OF MEDICAL RECORDS

(a) The manager of medical records service shall maintain medical records, whether original, computer media, or microfilm, for ~~a minimum of~~ 11 years following the discharge of an adult patient.

(b) The manager of medical records shall maintain medical records of a patient who is a minor until the patient's 30th birthday.

(c) If a hospital discontinues operation, its management shall make known to the Division where its records are stored. Records shall be stored in a business offering retrieval services for ~~at least~~ 11 years after the closure date.

~~(d) The hospital shall give public notice prior to destruction of its records, to permit former patients or representatives of former patients to claim the record of the former patient. Public notice shall be in at least two forms: written notice to the former patient or their representative and display of an advertisement in a newspaper of general circulation in the area of the facility.~~

~~(e)~~ (d) The manager of medical records may authorize the microfilming of medical records. Microfilming may be done on or off the premises. If done off the premises, the facility shall provide for the confidentiality and safekeeping of the records. The original of microfilmed medical records shall not be destroyed until the medical records department has had an opportunity to review the processed film for content.

~~(f)~~ (e) Nothing in this Section shall be construed to prohibit the use of automation in the medical records service, provided that all of the provisions in this Rule are met and the information is readily available for use in patient care.

~~(g)~~ (f) Only personnel authorized by ~~state~~ State laws and Health Insurance Portability and Accountability Act (HIPAA) regulations shall have access to medical records. Where the written authorization of a patient is required for the release or disclosure of health information, the written authorization of the patient or authorized representative shall be maintained in the original record as authority for the release or disclosure.

~~(h)~~ (g) Medical records are the property of the hospital, and they shall not be removed from the facility jurisdiction except through a court order. Copies shall be made available for authorized purposes such as insurance claims and physician review.

History Note: *Authority G.S. ~~90-21.20B;~~ 131E-75(b); 131E-79; 131E-97;*
Eff. January 1, 1996;
Amended Eff. July 1, ~~2009.~~ 2009;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4103 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .4103 PROVISION OF EMERGENCY SERVICES

(a) Any ~~of any~~ facility providing emergency services shall establish and maintain policies requiring ~~appropriate~~ medical screening, treatment and transfer services for any individual who presents to the facility emergency department and on whose behalf treatment is requested regardless of that person's ability to pay for medical services and without delay to inquire about the individual's method of payment.

(b) Any facility providing emergency services under the rules of this Section shall install, ~~operate~~ operate, and maintain, on a 24-hour per day basis, an emergency two-way radio ~~licensed by the Federal Communications Commission in the Public Safety Radio Service~~ capable of ~~establishing~~ accessing the North Carolina Voice Interoperability Plan for Emergency Responders (VIPER) radio network for voice ~~radio~~ communication with ~~ambulance units~~ EMS providers transporting patients to ~~said~~ the facility or ~~having any written procedure or agreement for handling emergency services with the local ambulance service, rescue squad or other trained medical~~ or provide on-line medical direction for EMS personnel.

(c) All communication equipment shall be in compliance with ~~current~~ the rules ~~established by North Carolina Rules for Basic Life Support/Ambulance Service (10 NCAC 3D .1100) adopted by reference with all subsequent amendments. Referenced rules are available at no charge from the Office of Emergency Medical Services, 2707 Mail Service Center, Raleigh, N.C. 27699-2707.~~ set forth in 10A NCAC 13P, Emergency Medical Services and Trauma Rules.

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4104 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .4104 MEDICAL DIRECTOR

(a) The governing body shall establish the qualifications, duties, and authority of the director of emergency services. Appointments shall be recommended by the medical staff and approved by the governing body.

(b) The medical staff credentials committee shall approve the mechanism for emergency privileges for physicians employed for brief periods of time such as evenings, ~~weekends~~ weekends, or holidays.

(c) Level I and II emergency services shall be directed and supervised by a ~~physician with experience in emergency care.~~ physician.

(d) Level III services shall be directed and supervised by a ~~physician with experience in emergency care or through a multi-disciplinary medical staff committee. The chairman of this committee shall serve as director of emergency medical services.~~ physician.

History Note: *Authority G.S. 131E-75(b); 131E-79; 131E-85(a);*
RRC objection due to lack of statutory authority Eff. July 13, 1995;

Eff. January 1, ~~1996.~~ 1996;

Readopted Eff. July 1, 2022.

10A NCAC 13B .4106 is proposed for readoption without substantive changes as follows:

10A NCAC 13B .4106 POLICIES AND PROCEDURES

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

(1) the location, storage, and procurement of medications, blood, supplies, equipment and the procedures to be followed in the event of equipment failure;

(2) the initial management of patients with burns, hand injuries, head injuries, fractures, multiple injuries, poisoning, animal bites, gunshot or stab ~~wounds~~ wounds, and other acute problems;

(3) the provision of care to an unemancipated minor not accompanied by a parent or guardian, or to an unaccompanied unconscious patient;

(4) management of alleged or suspected child, ~~elder~~ elder, or adult abuse;

(5) the management of pediatric emergencies;

(6) the initial management of patients with actual or suspected exposure to radiation;

(7) management of alleged or suspected rape victims;

(8) the reporting of individuals dead on arrival to the proper authorities;

(9) the use of standing orders;

(10) tetanus and rabies prevention or prophylaxis; and

(11) the dispensing of medications in accordance with ~~state~~ State and federal laws.

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4305 is proposed for readoption without substantive changes as follows:

10A NCAC 13B .4305 ORGANIZATION OF NEONATAL SERVICES

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

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

(2) LEVEL II: Neonates or infants that are stable without complications but require special care and frequent feedings; infants of any weight who no longer require Level III or LEVEL IV neonatal

services, but who still require more nursing hours than normal infant. This may include infants who require close observation in a licensed acute care ~~bed~~ bed.

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

(4) LEVEL IV (Neonatal Intensive Care Services): High-risk, medically unstable or critically ill neonates approximately under 32 weeks of gestational age, or infants, requiring constant nursing care or supervision ~~not limited to~~ that includes continuous cardiopulmonary or respiratory support, complicated surgical procedures, or other intensive supportive interventions.

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

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

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, 1996;
Temporary Amendment Eff. March 15, 2002;
Amended Eff. April 1, ~~2003.~~ 2003;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4603 is proposed for readoption without substantive changes as follows:

10A NCAC 13B .4603 SURGICAL AND ANESTHESIA STAFF

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

~~(b) The facility shall require that:~~

(1) when anesthesia is administered, a ~~qualified~~ physician is ~~immediately~~ available in the facility to provide care in the event of a medical emergency;

(2) a roster of practitioners with a delineation of current surgical and anesthesia privileges is available and maintained for the service;

(3) an on-call schedule of surgeons with privileges to be available at all times for emergency surgery and for post-operative clinical management is maintained;

(4) the operating room is supervised by a ~~qualified~~ registered nurse or doctor of medicine or osteopathy; and

(5) an operating room register which shall include date of the operation, name and patient identification number, names of surgeons and surgical assistants, name of anesthetists, type of anesthesia given, pre- and post-operative diagnosis, type and duration of surgical procedure, and the presence or absence of complications in surgery is maintained.

History Note: *Authority G.S. 131E-75(b); 131E-79; 131E-85;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4801 is proposed for readoption without substantive changes as follows:

SECTION .4800 - DIAGNOSTIC IMAGING

10A NCAC 13B .4801 ORGANIZATION

(a) Imaging services shall be under the supervision of a full-time radiologist, consulting radiologist, or a ~~physician~~ physician. ~~experienced in the particular imaging modality and the~~ The physician in charge ~~must~~ shall have the credentials required by facility policies.

(b) ~~Activities of the imaging service may include radio-therapy.~~ Radio-therapy is a type of imaging service.

(c) All imaging equipment shall be operated under professional supervision by ~~qualified~~ personnel trained in the use of imaging equipment and knowledgeable of all applicable safety precautions required by the North Carolina Department of ~~Environment and Natural Resources,~~ Health and Human Services, Division of ~~Environmental~~ Health Service Regulation, Radiation Protection ~~Section.~~ Section set forth in 10A NCAC 15, hereby incorporated by reference including subsequent amendments. ~~Copies of regulations are available from the N.C. Department of Environment and Natural Resources, Radiation Protection Section, 3825 Barrett Drive, Raleigh, NC 27609 at a cost of sixteen dollars ($16.00) each~~.

History Note: *Authority G.S. 131E-75(b); 131E-79;*
RRC objection due to lack of statutory authority and ambiguity Eff. July 13, 1995;
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4805 is proposed for readoption without substantive changes as follows:

10A NCAC 13B .4805 SAFETY

(a) The facility shall require that all imaging equipment is operated under the supervision of a physician and by qualified personnel.

(b) The facility shall require that proper caution is exercised to protect all persons from exposure to radiation.

(c) Safety inspections of the imaging department, including equipment, shall be conducted by the North Carolina Division of ~~Environmental Health,~~ Health Service Regulation, Radiation Protection ~~Services~~ Section. Copies of the report shall be available for review by the Division.

(d) The governing authority shall appoint a radiation safety committee. The committee shall ~~include but is not limited to:~~ include:

(1) a physician experienced in the handling of radio-active isotopes and their therapeutic use; and

(2) other representatives of the medical staff.

(e) All radio-active isotopes, whether for diagnostic, therapeutic, or research purposes shall be received, handled, and disposed of in accordance with the requirements of the North Carolina Department of ~~Environment and Natural Resources,~~ Health and Human Services, Division of ~~Environmental Health,~~ Health Service Regulation, Radiation Protection ~~Services Section.~~ Section set forth in 10A NCAC 15, hereby incorporated by reference including subsequent amendments. ~~Copies of regulations are available from the North Carolina Department of Environment, Health, and Natural Resources, Division of Radiation Protection, 3825 Barrett Drive, Raleigh, NC 27609 at a cost of six dollars ($6.00) each.~~

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .5102 is proposed for readoption without substantive changes as follows:

10A NCAC 13B .5102 POLICY AND PROCEDURES

(a) Each facility department or service shall establish and maintain written infection control policies and procedures. These shall ~~include but are not limited to:~~ include:

(1) the role and scope of the service or department in the infection control program;

(2) the role and scope of surveillance activities in the infection control program;

(3) the methodology used to collect and analyze data, maintain a surveillance program on nosocomial infection, and the control and prevention of infection;

(4) the specific precautions to be used to prevent the transmission of infection and isolation methods to be utilized;

(5) the method of sterilization and storage of equipment and supplies, including the reprocessing of disposable items;

(6) the cleaning of patient care areas and equipment;

(7) the cleaning of non-patient care areas; and

(8) exposure control plans.

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

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

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff July 1, 2022.

10A NCAC 13B .5105 is proposed for readoption without substantive changes as follows:

10A NCAC 13B .5105 STERILE SUPPLY SERVICES

The facility shall provide for the following:

(1) decontamination and sterilization of equipment and supplies;

(2) monitoring of sterilizing equipment on a routine schedule;

(3) establishment of policies and procedures for the use of disposable items; and

(4) establishment of policies and procedures addressing shelf life of stored sterile items.

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .5406 is proposed for readoption without substantive changes as follows:

10A NCAC 13B .5406 DISCHARGE CRITERIA FOR INPATIENT REHABILITATION FACILITIES OR UNITS

(a) Discharge planning shall be an integral part of the patient's treatment plan and shall begin upon admission to the facility. After established goals have been reached, or a determination has been made that care in a less intensive setting would be appropriate, or that further progress is unlikely, the patient shall be discharged to an appropriate setting. Other reasons for discharge may include an inability or unwillingness of patient or family to cooperate with the planned therapeutic program or medical complications that preclude a further intensive rehabilitative effort. The facility shall involve the patient, family, staff ~~members~~ members, and referral sources in discharge planning.

(b) The case manager shall facilitate the discharge or transfer process in coordination with the facility social worker.

(c) If a patient is being referred to another facility for further care, ~~appropriate~~ documentation of the patient's current status shall be forwarded with the patient. A ~~formal~~ discharge summary shall be forwarded within 48 hours following discharge and shall include the reasons for referral, the diagnosis, functional limitations, services provided, the results of services, referral action ~~recommendations~~ recommendations, and activities and procedures used by the patient to maintain and improve functioning.

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. March 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .5408 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .5408 COMPREHENSIVE INPATIENT REHABILITATION PROGRAM STAFFING REQUIREMENTS

(a) The staff of the inpatient rehabilitation facility or unit shall ~~include at a minimum:~~ include:

(1) the inpatient rehabilitation facility or unit shall be supervised by a rehabilitation ~~nurse.~~ nurse as defined in Rule .5401 of this Section. The facility shall ~~identify the nursing skills necessary to meet the needs of the rehabilitation patients in the unit and~~ assign staff qualified to meet those needs;

(2) the minimum nursing hours per patient in the rehabilitation unit shall be 5.5 nursing hours per patient day. At no time shall direct care nursing staff be less than two full-time equivalents, one of which must be a registered nurse;

(3) the inpatient rehabilitation unit shall employ or provide by contractual agreements ~~sufficient~~ therapist to provide ~~a minimum of~~ three hours of specific (physical, occupational or speech) or combined rehabilitation therapy services per patient day;

(4) physical therapy assistants and occupational therapy assistants shall be supervised on-site by physical therapists or occupational therapists;

(5) rehabilitation aides shall have documented training appropriate to the activities to be performed and the occupational licensure laws of his or her supervisor. The overall responsibility for the on-going supervision and evaluation of the rehabilitation aide remains with the registered nurse as identified in Subparagraph (a)(1) of this Rule. Supervision by the physical therapist or by the occupational therapist is limited to that time when the therapist is on-site and directing the rehabilitation activities of the aide; and

(6) hours of service by the rehabilitation aide are counted toward the required nursing hours when the aide is working under the supervision of the nurse. Hours of service by the rehabilitation aide are counted toward therapy hours during that time the aide works under the immediate, on-site supervision of the physical therapist or occupational therapist. Hours of service shall not be dually

counted for both services. Hours of service by rehabilitation aides in performing nurse-aide duties in areas of the facility other than the rehabilitation unit shall not be counted toward the 5.5 hour minimum nursing requirement described for the rehabilitation unit.

(b) Additional personnel shall be provided as required to meet the needs of the patient, as defined in the comprehensive inpatient rehabilitation evaluation.

History Note: *Authority G.S. 131E-75(b);131E-79;*
RRC Objection due to lack of statutory authority Eff. January 18, 1996;
Eff. May 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .5411 is proposed for readoption as a repeal as follows:

10A NCAC 13B .5411 PHYSICAL FACILITY REQUIREMENTS/INPATIENT REHABILITATION FACILITIES OR UNIT

History Note: *Authority G.S. 131E-79;*
Eff. March 1, ~~1996.~~ 1996;
Repealed Eff. January 1, 2022.

Licensing of Hospital Rules Readoption Public Comments
10A NCAC 13B .3801, .3903, .4103, .4104, .4106, .4305, .4603, .4801, .4805, .5102, .5105, .5406, .5408, and .5411
Comment Period 12/15/21 – 2/14/22

Exhibit C/3

Introduction:

One individual submitted comments during the public comment period on the readoption of rules 10A NCAC 13B .3801, .3903, .4103, .4104, .4106, .4305, .4603, .4801, .4805, .5102, .5105, .5406, .5408, and .5411. Of these comments, no one made statements during the public hearing conducted on January 5, 2022. The comments were submitted by a representative from the N.C. Healthcare Association. A summary of the comments received on these rules is below:

Comments Received and Agency's Consideration of Comments for Readoption Rule 13B .3903 – Preservation of Medical Records:

Commenter	Comment Summary
N.C. Healthcare Association	Supports the repeal of notification prior to destruction of records. Requests further conforming and clarifying revisions. Paragraphs (a) through (c): Use federal record retention guidelines of maintaining medical records for 7 years from the Date of Service (DOS). Suggestion Paragraph (a) & (b): *The manager of medical records services shall maintain medical records, whether original, computer media, microfilm, for at least 7 years from the date of service; for minors, 7 years after the minor turns the age of 18 (i.e., 25 years old).* Suggestion Paragraph (c): *For facilities that discontinue operation, records shall be stored in a business offering retrieval services for 7 years after the closure date* *(c1) A hospital may destroy medical records after the required retention period.* Paragraph (d): Include verbiage to help guide hospitals in documenting a destruction policy for legacy paper records. Suggestion Paragraph (d): *The manager of medical records may authorize the digital conversion (i.e., document imaging/scanning/conversion) of paper records. Digital conversion may be done on or off premises. The facility shall provide for the confidentially and safekeeping of records throughout the digital conversion process. The original medical records shall not be destroyed until the medical records department can review the processed records for content and accuracy. For historical records that are already digitized from use/originated from electronic medical record systems, organizations must abide by the same diligence for retention, destruction, conversion, confidentially, and safekeeping as paper medical records.* Paragraph (e): Add language for information blocking which is an action that is likely to obstruct, impede, or discourage electronic health information (EHI) access, sharing, or usage. Suggestion Paragraph (e): *Nothing in this Section shall be construed to prohibit the use of automation of medical record services if: (i) all the provisions in this Rule are met; and (ii) the information is readily*

Commenter	Comment Summary
	available for patient care and does not constitute information blocking as defined by the Office of Inspector General. Paragraph (f): Add in references to reflect current practices. Suggestion Paragraph (f): *Only personnel authorized by state laws, 42 C.F.R. Part 2, and Health Insurance Portability and Accountability Act (HIPAA) regulations shall have access to medical records. Where the written authorization of a patient or written assurances of the recipient of the information is required for the release or disclosure of health information, the written authorization of the patient or authorized representative, or the written assurances of the recipient, shall be maintained in the original record as authority for the release or disclosure.* Paragraph (g): revise the language reflect updated language regarding the removal of records from hospital property. Suggestion Paragraph (g): *Medical records, and copies thereof, are the property of the hospital, and they shall not be removed without the facility's consent except as required by law or regulation.*

Agency Response to Comments Above:

Comments are acknowledged with a staff recommendation to maintain the rules in the current state and allow hospitals to develop and implement polices to govern compliance with both state and federal regulations, to include the Clinical Laboratory Improvement Acts retention schedule. Hospital policies should address the following:

- Retention of medical records (e.g. original, computer media, microfilm, digital, electronic, legally reproduced, etc.)
- Destruction of medical records
- Access to medical records

42 CFR § 482.24 Condition of participation: Medical record services.
The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

(a) ***Standard: Organization and staffing.*** The organization of the medical record service must be appropriate to the scope and complexity of the services performed. The hospital must employ adequate personnel to ensure prompt completion, filing, and retrieval of records.

(b) ***Standard: Form and retention of record.*** The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication, and protects the security of all record entries.

CLIA Regulations: Retention Requirements 42 CFR § 493.1105 Sec. 493.1105 Standard:

(a) The laboratory must retain its records and, as applicable, slides, blocks, and tissues as follows:

(1) ***Test requisitions and authorizations.*** Retain records of test requisitions and test authorizations, including the patient's chart or medical record if used as the test requisition or authorization, for at least 2 years.

(2) ***Test procedures.*** Retain a copy of each test procedure for at least 2 years after a procedure has been discontinued. Each test procedure must include the dates of initial use and discontinuance

(3) ***Analytic systems records.*** Retain quality control and patient test records (including instrument printouts, if applicable) and records documenting all analytic systems activities specified in §§ 493.1252 through 493.1289 for at least 2 years. In addition, retain the following:

(i) Records of test system performance specifications that the laboratory establishes or verifies under § 493.1253 for the period of time the laboratory uses the test system but no less than 2 years.

(ii) Immunohematology records, blood and blood product records, and transfusion records as specified in 21 CFR 606.160(b)(3)(ii), (b)(3)(iv), (b)(3)(v) and (d).

(4) ***Proficiency testing records.*** Retain all proficiency testing records for at least 2 years.

(5) ***Quality system assessment records.*** Retain all laboratory quality systems assessment records for at least 2 years.

(6) ***Test reports.*** Retain or be able to retrieve a copy of the original report (including final, preliminary, and corrected reports) at least 2 years after the date of reporting. In addition, retain the following:

(i) Immunohematology reports as specified in 21 CFR 606.160(d).

(ii) Pathology test reports for at least 10 years after the date of reporting.

(7) ***Slide, block, and tissue retention*** -

(i) ***Slides.***

(A) Retain cytology slide preparations for at least 5 years from the date of examination (see § 493.1274(f) for proficiency testing exception).

(B) Retain histopathology slides for at least 10 years from the date of examination.

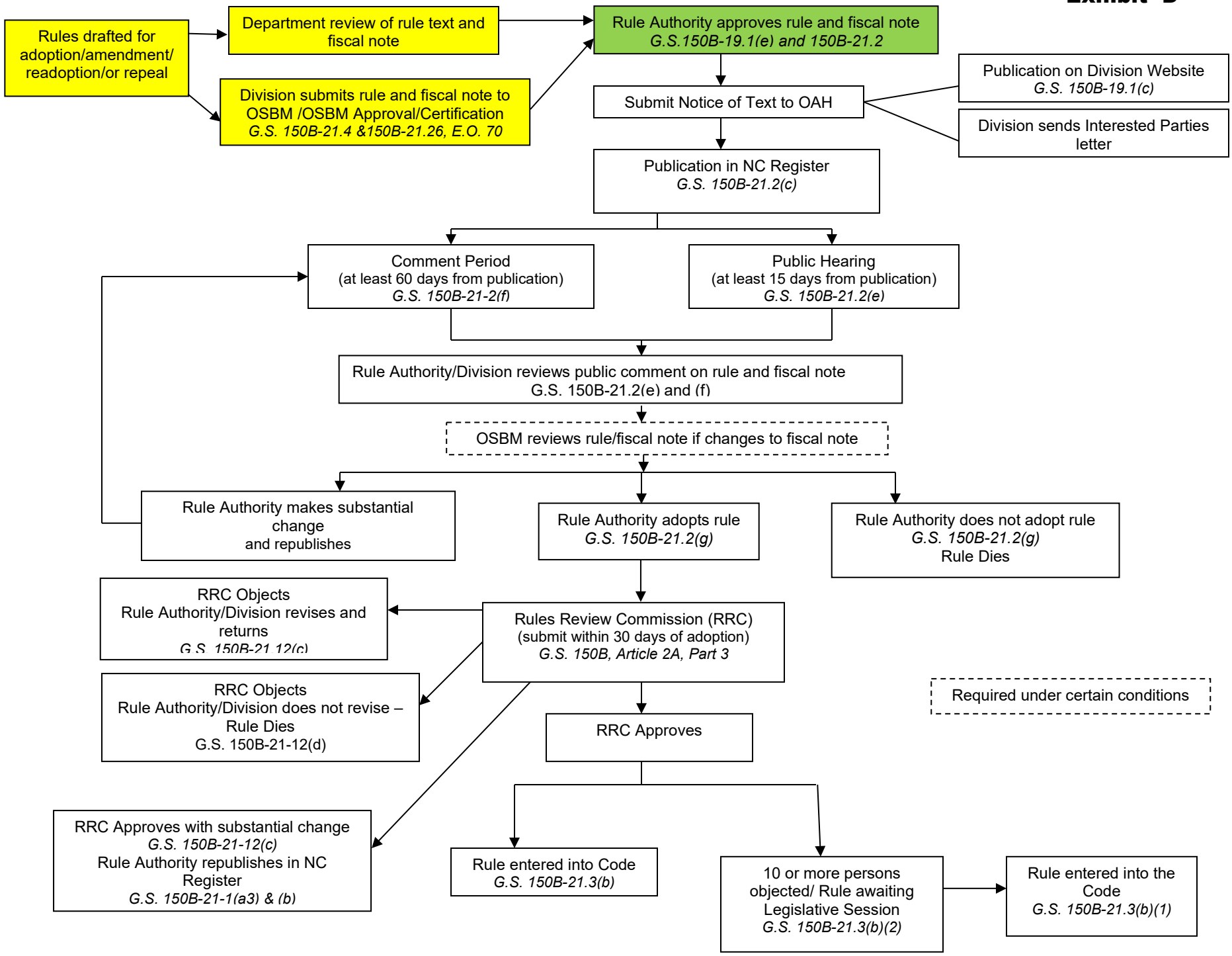
(ii) ***Blocks.*** Retain pathology specimen blocks for at least 2 years from the date of examination.

(iii) ***Tissue.*** Preserve remnants of tissue for pathology examination until a diagnosis is made on the specimen.

(b) If the laboratory ceases operation, the laboratory must make provisions to ensure that all records and, as applicable, slides, blocks, and tissue are retained and available for the time frames specified in this section.

Process for Medical Care Commission to Initiate Rulemaking

Exhibit D



10A NCAC 13F .0904 is proposed for readoption with substantive changes as follows:

10A NCAC 13F .0904 NUTRITION AND FOOD SERVICE

(a) Food Procurement and Safety in Adult Care Homes:

(1) ~~The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.~~ Facilities with a licensed capacity of 7 to 12 residents shall ensure food services comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food and beverage under sanitary conditions.

(2) ~~All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination.~~ Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Restaurants and Other Foodhandling Establishments set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions.

(3) 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,~~ menus established in Paragraph (c) of this Rule for both regular and therapeutic diets.

(b) Food Preparation and Service in Adult Care Homes:

(1) Sufficient staff, ~~space~~ space, and equipment shall be provided for safe and sanitary food storage, ~~preparation~~ preparation, and service.

(2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, ~~plate~~ 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 Adult Care Homes:

(1) Menus shall be prepared at least one week in advance with serving quantities specified and in accordance with the ~~Daily Food Requirements~~ 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~~ diets, and documented and maintained in the kitchen 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.~~ licensed dietitian/nutritionist. The facility shall maintain verification of the ~~registered dietitian's~~ licensed dietitian/nutritionist's approval of the therapeutic ~~diets which shall include an original signature by the registered dietitian and the registration number of the dietitian.~~ diets.

(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 Adult Care Homes:

(1) Each resident shall be served a minimum of three nutritionally ~~adequate,~~ adequate based on the requirements in Subparagraph (d)(3) of this Rule, palatable meals to the residents. Meals shall be served ~~a day~~ at regular ~~hours~~ times comparable to normal meal times in the community. There shall be ~~with~~ at least 10 hours between the breakfast and evening meals.

(2) Foods and beverages ~~that are appropriate to residents' diets~~ shall be offered in accordance with residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.

(3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost and include the following:

(A) ~~Homogenized whole milk, low fat milk, skim milk or buttermilk:~~ Dairy and dairy alternatives: milk, yogurt, cheese, low-lactose or lactose-free dairy products, fortified soy beverages, and soy yogurt. One cup (8 ounces) of ~~pasteurized milk~~ dairy or dairy alternatives at least ~~twice~~ three times a day. Milk served shall be pasteurized. 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.~~ only.

(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).~~ fruit; examples of one serving are as follows: 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~~ 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).~~ vegetables; examples

of one serving are as follows: 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~~ leafy, or deep yellow vegetables three times a week.

(D) Eggs: One whole egg or substitute ~~(e.g., 2 egg whites or ¼ cup of pasteurized egg product)~~ such as 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.,~~ (such as 4 tablespoons of peanut butter, 1 cup of cooked dried peas or ~~beans~~ 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:~~ For the purposes of this Rule, Bacon is considered to be fat and ~~not meat for the purposes of this Rule.~~ does not meet the protein requirement for meat.

(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~~ 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.,~~ (such as oatmeal or grits); ¾ cup ready-to-eat cereal; or one waffle, ~~pancake~~ 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~~ margarine, or items consisting primarily of one of ~~these (e.g., such as icing or gravy)~~ these, such as 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 Adult Care Homes:

(1) All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician. Where applicable, the therapeutic diet order shall be specific to calorie, ~~gram~~ gram, or consistency, such as for ~~calorie controlled~~ calorie-controlled ADA diets, low sodium ~~diets~~ diets, or thickened liquids, unless there are written orders ~~which~~ that include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a ~~registered dietitian.~~ licensed dietitian/nutritionist. For the purpose of this Rule "therapeutic diet" is a diet ordered by a physician or other delegated provider that is part of the treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium or potassium), or to provide mechanically altered food when indicated.

(2) Physician orders for nutritional supplements shall be in writing from the resident's physician and be ~~brand specific,~~ 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~~ a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.

(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.

(f) Individual Feeding Assistance in Adult Care Homes:

(1) ~~Sufficient~~ The facility shall provide staff ~~shall be available~~ for individual feeding assistance ~~as needed.~~ in accordance to residents' needs.

(2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.

(g) Variations from the required three meals or time intervals between meals to meet individualized needs or preferences of residents shall be documented in the resident's record.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1984;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, ~~2004.~~ 2004;
Readopted Eff. January 1, 2023.

10A NCAC 13G .0904 is proposed for readoption with substantive changes as follows:

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.~~ Food services shall comply with Rules Governing the Sanitation of Residential Care Facilities as promulgated by the Commission for Public Health which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food under sanitary conditions. Copies of these Rules can be accessed online at https://ehs.ncpublichealth.com/rules.htm, at no cost.

~~(2)~~ ~~All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination.~~

~~(3)~~(2) All meat processing shall occur at a USDA-approved processing plant.

~~(4)~~(3) 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,~~ menus established in Paragraph (c) of this Rule, for both regular and therapeutic diets.

(b) Food Preparation and Service in Family Care Homes:

(1) Sufficient staff, ~~space~~ space, and equipment shall be provided for safe and sanitary food storage, ~~preparation~~ preparation, and service.

(2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, ~~plate~~ 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~~ 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~~ diets, and documented and maintained in the kitchen 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.~~ licensed dietitian/nutritionist. The facility shall maintain verification of the ~~registered dietitian's~~ licensed dietitian/nutritionist's approval of the therapeutic ~~diets which shall include an original signature by the registered dietitian and the registration number of the dietitian.~~ diets.

(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,~~ adequate based on the requirements in Subparagraph (d)(3) of this Rule, palatable meals to the residents. Meals shall be served ~~a day~~ at regular ~~hours~~ times comparable to normal meal times in the community. There shall be ~~with~~ at least 10 hours between the breakfast and evening meals.

(2) Foods and beverages ~~that are appropriate to residents' diets~~ shall be offered in accordance with residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.

(3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary Guidelines for Americans 2020-2025, which are hereby incorporated by reference, including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf, at no cost and include the following:

(A) ~~Homogenized whole milk, low fat milk, skim milk or buttermilk.~~ Dairy and dairy alternatives: milk, yogurt, cheese, low-lactose or lactose-free dairy products, fortified soy beverages, and soy yogurt. One cup (8 ounces) of ~~pasteurized milk~~ dairy or dairy alternatives at least ~~twice~~ three times a day. Milk served shall be pasteurized. 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.~~ only.

(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).~~ fruit; examples of one serving are as follows: 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~~ 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).~~ vegetables; examples of one serving are as follows: 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~~ leafy, or deep yellow vegetables three times a week.

(D) Eggs: One whole egg or substitute ~~(e.g., 2 egg whites or ¼ cup of pasteurized egg product)~~ such as 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.,~~ (such as 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: For the purposes of this Rule, Bacon is considered to be fat and ~~not meat for the purposes of this Rule.~~ does not meet the protein requirement for meat.

(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.,~~ (such as oatmeal or grits); ¾ cup ready-to-eat cereal; or one waffle, ~~pancake~~ 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~~ margarine, or items consisting primarily of one of ~~these (e.g., icing or gravy)~~ these, such as 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~~ gram, or consistency, such as for ~~calorie controlled~~ calorie-controlled ADA diets, low sodium ~~diets~~ diets, or thickened liquids, unless there are written orders ~~which~~ that include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a ~~registered dietitian.~~ licensed dietitian/nutritionist. For the purpose of this Rule "therapeutic diet" is a diet ordered by a physician or other delegated provider that is part of the treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium or potassium), or to provide mechanically altered food when indicated.

(2) Physician orders for nutritional supplements shall be in writing from the resident's physician and be ~~brand specific,~~ 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~~ a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.

(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.

(f) Individual Feeding Assistance in Family Care Homes:

(1) ~~Sufficient~~ The facility shall provide staff ~~shall be available~~ for individual feeding assistance as ~~needed.~~ in accordance with residents' needs.

(2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.

(g) Variations from the required three meals or time intervals between meals to meet individualized needs or preferences of residents shall be documented in the resident's record.

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.~~ 2004;
Readopted Eff. January 1, 2023.

DHSR Adult Care Licensure Section
Fiscal Impact Analysis
Permanent Rule Readoption and Amendment with Substantial Economic Impact

Agency: North Carolina Medical Care Commission

Contact Persons: Nadine Pfeiffer, DHSR Rules Review Manager, (919) 855-3811
Megan Lamphere, Adult Care Licensure Section Chief, (919) 855-3784
Shalisa Jones, Regulatory Analyst, (704) 589-6214

Impact:

Federal Government:	No
State Government:	No
Local Government:	No
Private Entities:	Yes
Substantial Impact:	Yes

Titles of Rule Changes and N.C. Administrative Code Citation

Rule Readoptions (*See proposed text of these rules in Appendix)*
10A NCAC 13F .0904 Nutrition and Food Service
10A NCAC 13G .0904 Nutrition and Food Service

Authorizing Statutes: G.S. 131D-2.16; 131D-4.5; 143B-165

Introduction and Background

The agency is proposing to increase dairy serving requirements for adult and family care homes from 2 to 3 per day and expand the definition of dairy to include yogurt, cheese, low-lactose or lactose-free dairy products, fortified soy beverages, and soy yogurt. These proposed changes will align the rules with current United States Department of Agriculture (USDA) nutritional standards and provide facilities and residents with more dietary choices. Increasing the dairy requirements is expected to bring additional costs to the facilities that are not already offering dairy 3 times per day using the expanded definition of dairy.

The agency also proposes to reference applicable sanitation rules enforced by the Division of Public Health and make technical changes for clarity and consistency. These proposed changes do not affect current operations and have no economic impact. The agency does not anticipate any additional impact on state government or local government (i.e. county Departments of Social Services who monitor and conduct complaint investigations in adult care homes and family care homes) beyond their current job requirements to implement, monitor, or regulate the proposed amendments.

Under the authority of G.S. 150B-21.3A, Periodic review of existing rules, the North Carolina Medical Care Commission and Rules Review Commission approved the Subchapter reports with classifications for the rules under 10A NCAC 13F Licensing of Adult Care Homes of Seven or More Beds and 10 NCAC 13G Licensing of Family Care Homes. The rules were classified in the reports as

necessary with substantive public interest. Rules 13F .0904 and 13G .0904 are being presented for readoption with substantive changes. Most of the rules for both types of assisted living residences, adult care homes of seven beds or more and family care homes, are the same with the primary exception of staffing and physical plant requirements since they serve the same population based on need for care and services. Therefore, the 13F rules corresponding to the 13G rules being proposed for readoption with substantive changes are being amended concurrently to assure this traditional consistency.

Purpose and Benefits of Proposed Changes

The proposed changes update the language to include dietary options and serving requirements that align with the current USDA nutritional standards. The standards provide additional options for dairy, including dairy alternatives. The proposed language now includes yogurt, cheese, low-lactose/lactose-free dairy products, fortified soy beverages and soy yogurt. The USDA dietary guidelines provide a framework for dairy recommendations to include personal preferences, cultural inclusion, and budget-conscious options. Dairy foods are important to nutrition as it provides calcium and vitamin D needed for strong teeth and bones[1].

The USDA revised the dietary guidelines in December 2020 and the agency proposes to adopt those guidelines because the benefits of increased dairy intake have been proven to reduce falls and fractures among older adults residing in residential care. In an article published by BMJ today, "researchers in Australia, the Netherlands, and the United States completed a two-year trial that included at total of 7,195 residents with the mean age of 86 years old, thirty facilities were randomized to provide residents with additional milk, yogurt, and cheese, ultimately increasing the amount of calcium each day. Data from the trial confirmed risk reductions of 33% for all fractures, 46% of hip fractures, and 11% of falls"[3]. It was concluded, improving calcium and protein intakes by using dairy foods is a readily accessible intervention that reduces risk of falls and fractures commonly occurring in institutionalized older adults.

Estimated Costs to Facilities

The rule as written requires two 8-ounce servings of dairy daily shall be included in the daily menu for regular diets to include homogenized whole milk, low fat milk, skim milk, or buttermilk. While the proposed rules increase servings requirements from two to three 8-ounce servings per day, the expanded dairy options provide additional flexibility to operators.

The agency created and distributed surveys to providers in August 2021 and March 2022 to gather data regarding their current dairy serving frequency to determine how many of the 556 adult care homes and 537 family care homes may incur costs to comply with the proposed new dietary rules. The response rate for facilities answering dairy-related questions in the August survey was 19% for adult care homes and 12% for family care homes (15% total). The survey was refined and re-issued in March in an effort to improve the data available to estimate the impact of the proposed rules. The response rate from this survey was 30% for adult care homes and 11% for family care homes (16% total). Due to the low response rate, there is a high level of uncertainty about the number of facilities that will need to offer additional dairy servings under the new rules. The estimates in this analysis are based on the best data available to the agency.

Responses to the March 2022 survey indicate that 43% of adult care homes and 54% of family care homes (47% of all facilities) will need to increase the number of servings of dairy offered per day to comply with the proposed rules. The remaining 57% of the adult care home respondents and 46% of family care respondents are already serving 3 or more servings of dairy per day when considering the new, expanded definition of dairy (Tables 1 and 2).

Table 1. Number of Dairy Servings by Facility Type: Total Responses March 2022

Current Servings Per Day	Facility Type		Combined total
	Adult Care Home	Family Care Home	
1	4	6	10
2	46	26	72
3 or more	66	27	93
Total Respondents	166	59	175

Table 2. Number of Dairy Servings by Facility Type: Percentage of Total Responses

Current Servings Per Day	Facility Type		Combined total
	Adult Care Home	Family Care Home	
1	3%	10%	6%
2	40%	44%	41%
3 or more	57%	46%	53%
Total	100%	100%	100%

The Section estimated the average cost of compliance per facility for those that do not already serve dairy 3 or more times per day using the expanded definition (Table 3). The estimates are based on three components:

- Survey responses on the number of servings of dairy per day, used to estimate the proportion of facilities that would need to offer one or two additional servings of dairy
- The average number of residents in each facility that currently offers dairy less than 3 times per day, as reported in the survey, and
- USDA data on retail dairy prices in the Southeast as reported on March 25, 2022.[1]

This analysis presents the average annual costs for adult and family care homes, taking into account the proportion of facilities who would need to add one additional serving and facilities who would need to add two additional servings to comply with the proposed rules. There was a small amount of facilities who would need to offer two additional servings and a greater number of facilities who would need to offer only one additional serving (See Table 3). The agency recognizes that currently facilities are required to offer 2 servings of dairy per day, however the estimated average annual cost for adult and family care homes reflect data collected from facilities who currently offer one, two, and three or more servings per day to be inclusive of the current trends and obtain the most accurate estimated cost possible. The survey indicates that the proposed rule changes would incur costs for 47% of facilities. The remaining 53% of facilities are already offering the proposed 3 servings of dairy based on the new definition.

The agency's estimated an average cost for an 8oz serving of dairy of $1.28. This estimate was calculated by averaging the retail prices for the dairy products reported by the USDA, converted into costs per 8oz serving. USDA reports regional prices for several forms of cheese, ice cream, sour cream, and several forms of milk and yogurt by region. Butter was excluded from the calculation because butter is treated as a fat rather than dairy in the dietary rules. The agency chose to use the USDA data for the sake of consistency across providers and because requesting actual costs per serving of dairy from providers would likely be unsuccessful and unverifiable. It would be challenging for providers to develop an accurate calculation

[1] USDA Weekly Advertised Retail Prices.

based on the new definition and it would require a significant time investment for providers to obtain receipts for each dairy product purchased and report the information to the agency.

Estimated costs for adult care homes that do not already offer 3 servings of dairy under the expanded definition is $24,506 per facility, annually. For family care homes, estimated costs per facility would be $3,326 per facility, annually. See details in table 3.

Table 3. Estimated Average Annual Cost Per Facility by Type: Not Already Offering 3 Servings

Facility Type	Additional serving needed Percent of facilities	Average annual cost
Adult Care Homes	43%	$24,506
Family Care Homes	54%	$3,326

Due to the low survey response rate, there is a high level of uncertainty about the number of facilities that will need to offer additional dairy servings under the new rules. Similarly, there is variability in the per-serving cost of dairy depending on the chosen products and price fluctuations. Thus, total costs are uncertain. **However, this analysis suggests that the proposed rules will have a substantial economic impact[2] on facilities of approximately $5.9 million dollars per year for adult care homes and $1 million per year for family care homes statewide**. These costs were calculated by multiplying the estimated number of affected facilities (43% of the 556 adult care homes and 54% of the 537 family care homes) by the average annual cost per facility not already offering three servings of dairy under the expanded definition.

Alternatives

An alternate to the current proposed rules would be to keep the rules the same, making only technical changes that include no fiscal impact. However, keeping the rules the same would limit residents from potentially receiving additional servings of dairy which would not align with the current USDA standards. The current proposed rules are a better alternative as they align with current USDA standards offering more variety and increase in necessary vitamins which promote the health and well-being of residents.

A second alternative that could be considered in lieu of the proposed rules would include a further expanded definition of dairy alternatives based on the resident's preference which could include calcium and vitamin D fortified plant-based milk alternatives such as rice milk, oat milk, coconut milk, or almond milk to meet the preferences of residents. By proposing a more expanded definition of dairy, it would be challenging for providers and their staff when purchasing these additional plant-based alternatives as they would need to ensure that they contain the proper amounts of vitamin D and calcium to meet the dairy recommendations. The current proposed rules are a better alternative as they meet the minimum current USDA standards. The current proposed rules are clear, concise, and give providers a variety of options to increase dairy serving requirements with dairy alternatives, without the need to pay special attention to the nutritional labels. The current proposed rules include soy milk and soy yogurt as an alternative plant-based option to meet the calcium and vitamin D nutrient requirements for residents who require or prefer a plant-based alternative.

[2] Defined as greater than $1 million in costs and benefits in a 12-month period per G.S. 150B 21.4(b1)

Summary of Technical Changes: No Impact

1. The rule as written required the kitchen, dining, and food storage area to be clean, orderly, and protected from contamination. The proposed changes update the rules to include references to applicable sanitation rules enforced by the Division of Public Health. There is no fiscal impact as adherence to these rules are already mandated by the Commission for Public Health.

Rationale: Sanitation requirements are necessary to ensure cleanliness of the kitchen, dining, and food storage areas. Adult and family care home facilities are required to implement effective sanitation procedures to protect residents' food which helps to prevent foodborne illness. The sanitation rules as outlined in 15A NCAC 18A provide clear guidelines for food service equipment, utensils, food supplies, and food protection for adult care homes. Family Care homes will now have clear guidelines by complying with the Rules governing the Sanitation of Residential Care Facilities as promulgated by the Commission for Public Health. Inclusion of the sanitation rules for adult and family care homes will provide explicit regulations for how to ensure the kitchen, dining, and food storage areas are to be cleaned, orderly, and protected from contamination.

2. Additional technical changes were made to the rule to clarify the wording used to identify who is responsible for reviewing therapeutic diets. The language as written refers to the individuals as a "registered dietician". The proposed language was modified to match their practice act in Article 25 of Chapter 90 of the General Statues.

3. The rule as written provides vague instruction with the use of the phrase "nutritionally adequate". The language was updated to provide clarity for how "adequate" will be defined in Subparagraph (d)(3) of the Rule. Subparagraph (d)(3) of the rule indicated the requirements of daily menus. The current rule as written also requires that meals shall be served during "regular hours." The rule language was updated to clarify meals should be provided during the hours that are normal for the community to give facilities the ability to create meal times that honor residents' choice and the culture of the community.

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1 USDA Dietary Guidelines for Americans, 2020-2025
2 Data from the Adult Care Homes 2020 Facility License Renewal Applications
3(BMJ, 2021) "Effect of dietary sources of calcium and protein on hip fractures and falls in older adults in residential care: cluster randomized controlled trial"

Appendix

10A NCAC 13F .0904 is proposed for readoption with substantive changes as follows:

10A NCAC 13F .0904 NUTRITION AND FOOD SERVICE

(a) Food Procurement and Safety in Adult Care Homes:

(1) ~~The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.~~ Facilities with a licensed capacity of 7 to 12 residents shall ensure food services comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food and beverage under sanitary conditions.

(2) ~~All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination.~~ Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Restaurants and Other Foodhandling Establishments set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions.

(3) 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,~~ menus established in Paragraph (c) of this Rule for both regular and therapeutic diets.

(b) Food Preparation and Service in Adult Care Homes:

(1) Sufficient staff, ~~space~~ space, and equipment shall be provided for safe and sanitary food storage, ~~preparation~~ preparation, and service.

(2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, ~~plate~~ 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 Adult Care Homes:

(1) Menus shall be prepared at least one week in advance with serving quantities specified and in accordance with the ~~Daily Food Requirements~~ 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~~ diets, and documented and maintained in the kitchen 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.~~ licensed dietitian/nutritionist. The facility shall maintain verification of the ~~registered dietitian's~~ licensed

dietitian/nutritionist's approval of the therapeutic ~~diets which shall include an original signature by the registered dietitian and the registration number of the dietitian.~~ diets.

(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 Adult Care Homes:

(1) Each resident shall be served a minimum of three nutritionally ~~adequate,~~ adequate based on the requirements in Subparagraph (d)(3) of this Rule, palatable meals to the residents. Meals shall be served ~~a day~~ at regular ~~hours~~ times comparable to normal meal times in the community. There shall be ~~with~~ at least 10 hours between the breakfast and evening meals.

(2) Foods and beverages ~~that are appropriate to residents' diets~~ shall be offered in accordance with residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.

(3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost and include the following:

(A) ~~Homogenized whole milk, low fat milk, skim milk or buttermilk:~~ Dairy and dairy alternatives: milk, yogurt, cheese, low-lactose or lactose-free dairy products, fortified soy beverages, and soy yogurt. One cup (8 ounces) of ~~pasteurized milk~~ dairy or dairy alternatives at least ~~twice~~ three times a day. Milk served shall be pasteurized. 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.~~ only.

(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).~~ fruit; examples of one serving are as follows: 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~~ 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).~~ vegetables; examples of one serving are as follows: 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~~ leafy, or deep yellow vegetables three times a week.

(D) Eggs: One whole egg or substitute ~~(e.g., 2 egg whites or ¼ cup of pasteurized egg product)~~ such as 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.,~~ (such as 4 tablespoons of peanut butter, 1 cup of cooked dried peas or ~~beans~~ 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:~~ For the purposes of this Rule, Bacon is considered to be fat and ~~not meat for the purposes of this Rule.~~ does not meet the protein requirement for meat.

(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~~ 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.,~~ (such as oatmeal or grits); ¾ cup ready-to-eat cereal; or one waffle, ~~pancake~~ 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~~ margarine, or items consisting primarily of one of ~~these (e.g., such as icing or gravy)~~ these, such as 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 Adult Care Homes:

(1) All therapeutic diet orders including thickened liquids shall be in writing from the resident's physician. Where applicable, the therapeutic diet order shall be specific to calorie, ~~gram~~ gram, or consistency, such as for ~~calorie controlled~~ calorie-controlled ADA diets, low sodium ~~diets~~ diets, or thickened liquids, unless there are written orders ~~which~~ that include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a ~~registered dietitian.~~ licensed dietitian/nutritionist. For the purpose of this Rule "therapeutic diet" is a diet ordered by a physician or other delegated provider that is part of the treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium or potassium), or to provide mechanically altered food when indicated.

(2) Physician orders for nutritional supplements shall be in writing from the resident's physician and be ~~brand specific,~~ 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~~ a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.

(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.

(f) Individual Feeding Assistance in Adult Care Homes:

(1) ~~Sufficient~~ The facility shall provide staff ~~shall be available~~ for individual feeding assistance ~~as needed.~~ in accordance to residents' needs.

(2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.

(g) Variations from the required three meals or time intervals between meals to meet individualized needs or preferences of residents shall be documented in the resident's record.

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

Amended Eff. April 1, 1984;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. June 1, ~~2004.~~ 2004;
Readopted Eff. January 1, 2023.

10A NCAC 13G .0904 is proposed for readoption with substantive changes as follows:

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.~~ Food services shall comply with Rules Governing the Sanitation of Residential Care Facilities as promulgated by the Commission for Public Health which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food under sanitary conditions. Copies of these Rules can be accessed online at https://ehs.ncpublichealth.com/rules.htm, at no cost.

~~(2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination.~~

~~(3)~~(2) All meat processing shall occur at a USDA-approved processing plant.

~~(4)~~(3) 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,~~ menus established in Paragraph (c) of this Rule, for both regular and therapeutic diets.

(b) Food Preparation and Service in Family Care Homes:

(1) Sufficient staff, ~~space~~ space, and equipment shall be provided for safe and sanitary food storage, ~~preparation~~ preparation, and service.

(2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, ~~plate~~ 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~~ 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~~ diets, and documented and maintained in the kitchen 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.~~ licensed dietitian/nutritionist. The facility shall maintain verification of the ~~registered dietitian's~~ licensed dietitian/nutritionist's approval of the therapeutic ~~diets which shall include an original signature by the registered dietitian and the registration number of the dietitian.~~ diets.

(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,~~ adequate based on the requirements in Subparagraph (d)(3) of this Rule, palatable meals to the residents. Meals shall be served ~~a day~~ at regular ~~hours~~ times comparable to normal meal times in the community. There shall be ~~with~~ at least 10 hours between the breakfast and evening meals.

(2) Foods and beverages ~~that are appropriate to residents' diets~~ shall be offered in accordance with residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.

(3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary Guidelines for Americans 2020-2025, which are hereby incorporated by reference, including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf, at no cost and include the following:

(A) ~~Homogenized whole milk, low fat milk, skim milk or buttermilk:~~ Dairy and dairy alternatives: milk, yogurt, cheese, low-lactose or lactose-free dairy products, fortified soy beverages, and soy yogurt. One cup (8 ounces) of ~~pasteurized milk~~ dairy or dairy alternatives at least ~~twice~~ three times a day. Milk served shall be pasteurized. 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.~~ only.

(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).~~ fruit; examples of one serving are as follows: 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~~ 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).~~ vegetables; examples of one serving are as follows: 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~~ leafy, or deep yellow vegetables three times a week.

(D) Eggs: One whole egg or substitute ~~(e.g., 2 egg whites or ¼ cup of pasteurized egg product)~~ such as 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.,~~ (such as 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: For the purposes of this Rule, Bacon is considered to be fat and ~~not meat for the purposes of this Rule.~~ does not meet the protein requirement for meat.

(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.,~~ (such as oatmeal or grits); ¾ cup ready-to-eat cereal; or one waffle, ~~pancake~~ 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~~ margarine, or items consisting primarily of one of ~~these (e.g., icing or gravy)~~ these, such as 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~~ gram, or consistency, such as for ~~calorie controlled~~ calorie-controlled ADA diets, low sodium ~~diets~~ diets, or thickened liquids, unless there are written orders ~~which~~ that include the definition of any therapeutic diet identified in the facility's therapeutic menu approved by a ~~registered dietitian.~~ licensed dietitian/nutritionist. For the purpose of this Rule "therapeutic diet" is a diet ordered by a physician or other delegated provider that is part of the treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium or potassium), or to provide mechanically altered food when indicated.

(2) Physician orders for nutritional supplements shall be in writing from the resident's physician and be ~~brand specific,~~ 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~~ a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.

(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.

(f) Individual Feeding Assistance in Family Care Homes:

(1) ~~Sufficient~~ The facility shall provide staff ~~shall be available~~ for individual feeding assistance as ~~needed.~~ in accordance with residents' needs.

(2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.

(g) Variations from the required three meals or time intervals between meals to meet individualized needs or preferences of residents shall be documented in the resident's record.

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.~~ 2004;

Readopted Eff. January 1, 2023.

EXHIBIT E

NC MCC Bond Sale Approval Form						
Facility Name: Vidant Health						
	Time of Preliminary Approval					
SERIES: 2022B						
PAR Amount	$111,720,000.00					
Estimated Interest Rate [1]	1.38%					
All-in True Interest Cost	1.38%					
Maturity Schedule (Interest) - Date [2]	Monthly, 7/1/2022 - 10/1/2029					
Maturity Schedule (Principal) - Date	Annually, 12/1/2022 - 12/1/2036					
Bank Holding Period (if applicable) - Date	10/1/2029					
Estimated NPV Savings ($) (if refunded bonds)	$735,881					
Estimated NPV Savings (%) (if refunded bonds)	0.66%					
NOTES:						
1. Estimated variable interest rate is based on 5-year average of SOFR						
2. Represents interest payments to intial mandatory tender date of 10/1/2029						
Bonds are being refunding due to upcoming mandatory purchase dates and LIBOR cessation, not necessarily for refunding savings						
	Time of Preliminary Approval					
SERIES: 2022C						
PAR Amount	$37,360,000.00					
Estimated Interest Rate [1]	1.35%					
All-in True Interest Cost	1.35%					
Maturity Schedule (Interest) - Date [2]	Monthly, 7/1/2022 - 10/1/2029					
Maturity Schedule (Principal) - Date	Annually, 12/1/2022 - 12/1/2040					
Bank Holding Period (if applicable) - Date	10/1/2029					
Estimated NPV Savings ($) (if refunded bonds)	$875,938					
Estimated NPV Savings (%) (if refunded bonds)	2.34%					
NOTES:						
1. Estimated variable interest rate is based on 5-year average of BSBY						
2. Represents interest payments to intial mandatory tender date of 10/1/2029						
Bonds are being refunding due to upcoming mandatory purchase dates and LIBOR cessation, not necessarily for refunding savings						

EXHIBIT F

SCHEDULE OF FEES

Single Occupancy		Square Footage	Amortized Entry Fee	Monthly Service Fee
APARTMENTS				
Ash	1BDR	553	$ 97,970	$3,562
Beech	1BDR Expanded	717	131,676	4,128
Cedar	1 BDR with Den	914	195,045	4,672
Dogwood	2 BDR	1144	256,247	5,313
Elm	2 BDR with Den	1243	274,069	5,701
COTTAGES				
Alder	1BDR with Den	1207	294,316	5,412
Birch	2 BDR	1445	347,971	5,701
Chestnut	2 BDR with Den	1662	399,160	6,003
Pine	2 BDR with Study	2200	552,783	6,207
Holly	2 BDR with Study	2362	576,436	6,406
Magnolia	2 BDR with Study	2558	600,078	6,538

Double Occupancy				
APARTMENTS				
Ash	1 BDR	553	$ 135,970	$5,387
Beech	1 BDR Expanded	717	169,676	5,953
Cedar	1 BDR with Den	914	233,045	6.497
Dogwood	2 BDR	1144	294,247	7,138
Elm	2 BDR with Den	1243	312,069	7,526
COTTAGES				
Alder	1 BDR with Den	1207	332,316	7,237
Birch	2 BDR	1445	385,971	7,526
Chestnut	2 BDR with Den	1662	437,160	7,828
Pine	2 BDR with Study	2200	590,783	7,962
Holly	2 BDR with Study	2362	614,436	8,161
Magnolia	2 BDR with Study	2558	638,078	8,293

Effective October 1, 2021

NC MCC Bond Sale Approval Form		
Facility Name: The Forest at Duke		
	Time of Preliminary Approval	
SERIES: 2022 (Publicly Offered)		
PAR Amount	$53,030,000.00	
Estimated Interest Rate	5.50%	
All-in True Interest Cost	5.65%	
Maturity Schedule (Interest) - Date	03/01/2023 - 09/01/2053	
Maturity Schedule (Principal) - Date	09/01/2027 - 09/01/2053	
Bank Holding Period (if applicable) - Date	N/A	
Estimated NPV Savings ($) (if refunded bonds)	N/A	
Estimated NPV Savings (%) (if refunded bonds)	N/A	
NOTES:		
- Interest rate assumption assumes The Forest at Duke is rated BBB for the proposed financing.		
	Time of Preliminary Approval	
SERIES: Series 2022 (Bank Held)		
PAR Amount	$29,500,000.00	
Estimated Interest Rate	4.00%	
All-in True Interest Cost	4.15%	
Maturity Schedule (Interest) - Date	03/01/2023 - 09/01/2026	
Maturity Schedule (Principal) - Date	09/01/2026 - 09/01/2026	
Bank Holding Period (if applicable) - Date	N/A	
Estimated NPV Savings ($) (if refunded bonds)	N/A	
Estimated NPV Savings (%) (if refunded bonds)	N/A	
NOTES:		