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Sequence Number: 07-07-18
Rule ID(s): 7199-7204
File Date: 7/10/18
Effective Date: 10/8/18

Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission: Department of Health
Division: Board for Licensing Health Care Facilities
Contact Person: Kyonzte Hughes-Toombs, Deputy General Counsel
Address: 665 Mainstream Drive, Nashville, Tennessee
Zip: 37243
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Email: Kyonzte.Hughes-Toombs@tn.gov

Revision Type (check all that apply):

X Amendment
___ New
___ Repeal

Rule(s) (**ALL** chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please make sure that **ALL** new rule and repealed rule numbers are listed in the chart below. Please enter only **ONE** Rule Number/Rule Title per row)

Chapter Number	**Chapter Title**
1200-08-01	Standards for Hospitals
Rule Number	**Rule Title**
1200-08-01-.01	Definitions
1200-08-01-.05	Admissions, Discharges, and Transfers
1200-08-01-.06	Basic Hospital Functions
1200-08-01-.07	Optional Hospital Services

Chapter Number	**Chapter Title**
1200-08-06	Standards for Nursing Homes
Rule Number	**Rule Title**
1200-08-06-.01	Definitions

Chapter Number	**Chapter Title**
1200-08-10	Standards for Ambulatory Surgical Treatment Centers
Rule Number	**Rule Title**
1200-08-10-.04	Administration
1200-08-10-.11	Records and Reports

Chapter Number	Chapter Title
1200-08-11	Standards for Homes for the Aged
Rule Number	**Rule Title**
1200-08-11-.01	Definitions

Chapter Number	Chapter Title
1200-08-25	Standards for Assisted-Care Living Facilities
Rule Number	**Rule Title**
1200-08-25-.02	Definitions
1200-08-25-.03	Licensing Requirements
1200-08-25-.07	Services Provided
1200-08-25-.08	Admissions, Discharges, and Transfers
1200-08-25-.10	Life Safety

Chapter Number	Chapter Title
1200-08-34	Standards for Home Care Organizations Providing Professional Support Services
Rule Number	**Rule Title**
1200-08-34-.05	Admissions, Discharges, and Transfers

Place substance of rules and other info here. Please be sure to include a detailed explanation of the changes being made to the listed rule(s). Statutory authority must be given for each rule change. For information on formatting rules go to http://sos-tn-gov-files.s3.amazonaws.com/forms/Rulemaking%20Guidelines_September2016.pdf.

Chapter 1200-08-01
Standards for Hospitals
Amendments

Rule 1200-08-01-.01 Definitions is amended by deleting paragraph (24) in its entirety and substituting instead the following language and is further amended by adding new paragraph (45) and renumbering the remaining paragraphs accordingly, so that as amended, the new paragraphs shall read:

(24) Dietitian. As used in the chapter, the term "dietitian" means:

(a) A person who is currently licensed by the Tennessee Board of Dietitian/Nutritionist Examiners as a dietitian/nutritionist; or

(b) An employee of a Tennessee hospital who is exempt from Tennessee licensure pursuant to T.C.A. § 63-25-104(b)(6) but holds the credential of Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN) from the Commission on Dietetic Registration.

(45) Licensed health care professional. Any health care professional currently licensed by the State of Tennessee to practice within the scope of a regulated profession, such as a nurse practitioner, dietitian, dentist, occupational therapist, pharmacist, physical therapist, physician, physician assistant, podiatrist, psychologist, clinical social worker, speech language pathologist, and emergency service personnel.

Authority: T.C.A. §§ 39-11-106, 68-11-202, 68-11-204, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-224, 68-11-255, 68-11-1802, 68-57-101, 68-57-102, and 68-57-105.

Rule 1200-08-01-.05 Admissions, Discharges, and Transfers is amended by deleting paragraphs (1), (2), and (5) in their entirety and substituting instead the following language, so that as amended, the new paragraphs shall read:

(1) Every person admitted for care or treatment as an inpatient to any hospital covered by these rules shall be under the supervision of a physician who holds an unlimited license to practice in Tennessee. The name of the patient's attending physician shall be recorded in the patient's medical record.

(2) The above does not preclude the admission of a patient to a hospital by licensed health care professional, licensed to practice in Tennessee with the concurrence of a credentialed MD/DO also licensed to practice in Tennessee if admission by a category of licensed health care professionals is provided for in the medical staff bylaws. The licensed health care professional may also provide on call services to patients in the hospital if on call services for a category of licensed health care professionals is so provided for in the medical staff bylaws. The name of the attending licensed health care professional shall be recorded in the patient medical record as well as the name of the credentialed MD/DO. If a hospital allows these licensed health care professionals to admit and care for patients, as allowed by state law, the governing body and medical staff shall establish policies and bylaws, if necessary, to ensure that the requirements of 42 CFR part 482 are met.

(5) Except in emergency situations, no medication or treatment shall be given or administered to any inpatient in a hospital except on the order of a physician, dentist, or podiatrist lawfully authorized to give such an order. This requirement shall not apply to physical therapy, occupational therapy or speech language pathology services being provided in an outpatient setting when the services are being provided consistent with the scope of practice of physical therapists, occupational therapists and speech language pathologists as set forth in their respective practice acts found in Tennessee Code Annotated, Title 63, Chapters 13 and 17.

Authority: T.C.A. §§ 68-11-202, 68-11-204, 68-11-209, and 68-11-255.

Rule 1200-08-01-.06 Basic Hospital Functions is amended by deleting parts (9)(e)1 and (9)(e)2 in their entirety

and substituting instead the following language, so that as amended, the new parts shall read:

1. Individual patient nutritional needs must be met in accordance with recognized dietary practices.

2. All patient diets, including therapeutic diets, must be ordered by a practitioner responsible for the care of the patient, or by a qualified dietitian to whom the physician who chairs the hospital's medical executive committee has referred this task. The medical staff and hospital's board of trustees shall decide the extent of ordering privileges that a qualified dietitian shall have and a mechanism to ensure that order writing by a qualified dietitian is coordinated with the responsible practitioner's care of the patient and complies with Tennessee law governing dietitians.

Authority: T.C.A. §§ 68-3-511, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.

Rule 1200-08-01-.07 Optional Hospital Services is amended by deleting subparagraph (6)(e) in its entirety and substituting instead the following language, so that as amended, the new subparagraph shall read:

(e) Services must be furnished in accordance with a written plan of treatment in accordance with the practice acts of the practitioners who are authorized by medical staff to provide the services. The written plan of treatment must be incorporated in the patient's record.

Authority: T.C.A. §§ 68-11-202, 68-11-204, 68-11-209, 68-57-101, 68-57-102, 68-57-104 and 68-57-105.

Chapter 1200-08-06
Standards for Nursing Homes
Amendments

Rule 1200-08-06-.01 Definitions is amended by deleting paragraph (47) in its entirety and renumbering the remaining paragraphs.

Authority: T.C.A. §§ 39-11-106, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-224, 68-11-234, 68-11-1802, and 71-6-121.

Chapter 1200-08-10
Standards for Ambulatory Surgical Treatment Centers
Amendments

Rule 1200-08-10-.04 Administration is amended by deleting part (20)(b)3 in its entirety and substituting instead the following language, and is further amended by deleting part (20)(b)4 in its entirety and renumbering the remaining parts, so that as amended, the new part shall read:

3. The layout of patient care areas of the ASTC, as well as the personal items offered to the patient, shall be outlined in the ASTC's policy and be based on the type of procedure performed on the patient.

Authority: T.C.A. §§ 39-15-202, 39-17-1803, 39-17-1805, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-216, 68-11-268 and 71-6-121.

Rule 1200-08-10-.11 Records and Reports is amended by deleting paragraph (3) in its entirety and substituting instead the following language, so that as amended, the new paragraph shall read;

(3) The ASTC shall report to the department each patient case of communicable disease detected in the center. Repeated failure to report communicable diseases shall be cause for revocation of an ASTC's license. The ASTC shall monitor outbreaks of communicable diseases in the nearby geographical area of the facility and inform the ASTC staff of these outbreaks in order for the employees to contact their personal physician for consultation regarding their vaccination status.

Authority: T.C.A. §§ 68-1-1004, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, and 68-11-216.

Chapter 1200-08-11
Standards for Homes for the Aged
Amendments

Rule 1200-08-11-.01Definitions is amended by deleting paragraph (37) in its entirety and renumbering the remaining paragraphs.

Authority: T.C.A. §§ 39-11-106, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-216, 68-11-224, and 68-11-1802.

Chapter 1200-08-25
Standards for Assisted-Care Living Facilities
Amendments

Rule 1200-08-25-.02 Definitions is amended by deleting paragraph (20) in its entirety and substituting instead the following language, so that as amended, the new paragraph shall read:

(20) "Licensed health care professional" means:

(a) Any health care professional currently licensed by the State of Tennessee to practice within the scope of a regulated profession, such as a nurse practitioner, dietitian, dentist, occupational therapist, pharmacist, physical therapist, physician, physician assistant, psychologist, social worker, speech-language pathologist, and emergency service personnel; or

(b) A medication aide (as defined in Tennessee Code Annotated § 63-7-127).

Authority: T.C.A. §§ 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-210 and 68-11-211.

Rule 1200-08-25-.02 Definitions is amended by adding new paragraph (25) and renumbering the remaining paragraphs, and is further amended by deleting newly-numbered paragraph (37) in its entirety and substituting instead the following language, so that as amended, the new paragraphs shall read:

(25) "Medication Aide" means an individual who administers medications, as set forth in Tennessee Code Annotated § 63-7-127, under the general supervision of a licensed nurse pursuant to this section.

(37) "Secured unit" means a distinct part of an ACLF where the residents are intentionally denied egress except as is necessary to comply with life safety requirements.

Authority: T.C.A. §§ 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-210 and 68-11-211.

Rule 1200-08-25-.03 Licensing Requirements is amended by deleting part (9)(b)3 in its entirety and substituting instead the following language, so that as amended, the new part shall read:

3. Proof that the applicant is at least twenty-one (21) years of age;

Authority: T.C.A. §§ 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-208, 68-11-209, 68-11-213 and 68-11-216.

Rule 1200-08-25-.07 Services Provided is amended by deleting subparagraphs (5)(b) and (5)(c) in their entirety and substituting instead the following language, and is further amended by adding new subparagraphs (5)(d) and (5)(e), so that as amended, the new subparagraphs shall read:

(b) Ensure that all drugs and biologicals shall be administered by a licensed or certified health care professional operating within the scope of the professional license or certification and according to the resident's plan of care.

(c) Ensure that during the course of administering medication, a medication aide shall not be assigned any other non-medication administration duties. However, a medication aide shall not be precluded from responding, as appropriate, to an emergency;

(d) Store all medications via a locked or closed container and/or room which includes, but is not limited to, some type of box, piece of furniture, an individual resident room, and/or a designated room within the facility which maintains resident medication out of the sight of other residents; and

(e) Ensure that facility staff shall not repackage medication and shall not administer medication from repackaging.

Authority: T.C.A. §§ 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209 and 68-11-261.

Rule 1200-08-25-.07 Services Provided is amended by deleting subparagraph (6)(f) in its entirety and substituting instead the following language, so that as amended, the new subparagraph shall read:

(f) The ACLF's medication disposal policy shall be performed by a licensed or certified health care professional and either the facility's administrator, or a second licensed or certified health care professional.

Authority: T.C.A. §§ 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209 and 68-11-261.

Rule 1200-08-25-.08 Admissions, Discharges, and Transfers is amended by deleting subparagraph (9)(a) in its entirety and substituting instead the following language, so that as amended, the new subparagraph shall read:

(a) Documentation that an interdisciplinary team consisting of at least a physician, a registered nurse, and a family member (or patient care advocate) has evaluated each secured resident prior to admittance to the unit;

Authority: T.C.A. §§ 68-11-201(5), 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-211, 68-11-263 and 68-11-266.

Rule 1200-08-25-.10 Life Safety is amended by deleting subparagraphs (2)(i) and (2)(n) in their entirety and substituting instead the following language, so that as amended, the new subparagraphs shall read:

(i) Ensure that upon entering the ACLF, the resident or his or her responsible party is asked if they wish to have a cooking appliance that is appropriate for their level of cognition. If the facility chooses to provide a requested cooking appliance, it shall be used in accordance with the facility's policies. If the resident or his or her responsible party wishes to provide their own cooking appliance, it shall meet the facility's policies and safety standards. The cooking appliances shall be designed so that they can be disconnected and removed for resident safety or if the resident chooses not to have cooking capability within his or her apartment. The cooking appliances shall have an automatic timer.

(n) Provide and mount fire extinguishers and maintain travel distance between fire extinguishers, complying with NFPA 10, so they are accessible to all residents in the kitchen, laundries and at all exits.

Authority: T.C.A. §§ 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211 and 68-11-213.

Chapter 1200-08-34
Standards for Home Care Organizations Providing Professional Support Services
Amendments

Rule 1200-08-34-.05 Admissions, Discharges, and Transfers is amended by deleting paragraph (10) and subparagraphs (10)(a) and (10)(b) in their entirety and substituting the following language, so that as amended, the new paragraph and subparagraphs shall read:

(10) The agency's discharge planning process, including discharge policies and procedures, must be in writing and follow the guidelines established in the written agreement between the agency and the Department of

Intellectual and Developmental Disabilities (DIDD). If the agency determines that they are no longer willing or able to provide services, they must comply with the following:

(a) Prior to discontinuation of authorized services, the agency shall obtain approval from the DIDD;

(b) The agency shall notify the consumer, their conservator or guardian, the support coordinator, and DIDD no less than sixty (60) days prior to the planned discharge;

Authority: T.C.A. §§ 68-11-202 and 68-11-209.

* If a roll-call vote was necessary, the vote by the Agency on these rulemaking hearing rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)
Carissa S. Lynch, Pharm.D.				X	
Renee Saunders, M.D.	X				
Thomas Gee	X				
John A. Marshall	X				
Jennifer Gordon-Maloney, DDS	X				
Kenneth R. Robertson, M.D.	X				
Sherry Robbins, M.D.	X				
Annette Marlar	X				
Robert C. Breeden	X				
Roger L. Mynatt	X				
Janet Williford	X				
David Rhodes				X	
Joshua A. Crisp	X				
Gina Throneberry	X				
Paul Boyd	X				
Bobby Wood	X				
Jim Shulman	X				
Vacant					
Vacant					

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Board for Licensing Health Care Facilities (board/commission/ other authority) on 02/08/2017 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: *09/09/16 (mm/dd/yy)*

Rulemaking Hearing(s) Conducted on: (add more dates). *02/08/17 (mm/dd/yy)*

Date: 6/11/18

Signature: Kyonzté Hughes-Toombs

Name of Officer: Kyonzté Hughes-Toombs

Title of Officer: Deputy General Counsel
Department of Health

Subscribed and sworn to before me on: 6-11-18

Notary Public Signature: Suzanne Mechkowski

My commission expires on: My Commission Expires January 26, 2021

SUZANNE MECHKOWSKI NOTARY PUBLIC STATE OF TENNESSEE SUMNER COUNTY

Agency/Board/Commission: Board for Licensing Health Care Facilities

Rule Chapter Number(s): 1200-08-01; 1200-08-06; 1200-08-10; 1200-08-11; 1200-08-25; 1200-08-34

Agency/Board/Commission: Board for Licensing Health Care Facilities

Rule Chapter Number(s): 1200-08-01; 1200-08-06; 1200-08-10; 1200-08-11; 1200-08-25; 1200-08-34

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III
Attorney General and Reporter

7/2/2018
Date

Department of State Use Only

Filed with the Department of State on: 7/10/18

Effective on: 10/8/18

Tre Hargett
Secretary of State

Public Hearing Comments

One copy of a document that satisfies T.C.A. § 4-5-222 must accompany the filing.

Board for Licensing Health Care Facilities
Rulemaking Hearing
February 8, 2017

Public Comments

The Department received two written comments and one oral comment regarding the proposed new rule chapter.

One written comment was submitted by the Tennessee Medical Association ("TMA"). TMA requested that the following corrections be made to the proposed new rule chapter:

"Licensed or certified health care professional" should be defined. Further, on page 6, LPN and RN should be deleted from the list of licensed or certified health care professionals. Additionally, on page 17, TMA suggested language clarifying that categories of practitioners could admit and/or deliver on-call services if it is provided for in the medical staff bylaws.

A second written comment was received from John Williams of Tune, Entrekin & White, P.C. on behalf of the state association of podiatrists. As written, the proposed change to Rule 1200-08-01-.05(2) would eliminate the ability of a podiatrist or dentist to admit a patient to a hospital "with the concurrence of a physician member of the medical staff." Mr. Williams wanted to know whether the change was inadvertent or intentional. On behalf of the association, Mr. Williams did not want the ability of podiatrists and dentists to admit patients to be removed.

During the rulemaking hearing, Christopher Puri, on behalf of THCA, suggested the following revision to Rule 1200-08-25-.10(2)(i) in regard to cooking appliances in Assisted Care Living Facilities:

"Ensure that upon entering the ACLF that the resident or his or her responsible party is asked if they wish to have a cooking appliance that is appropriate for their level of cognition. If the facility chooses to provide a requested cooking appliance, it shall be used in accordance with the facility's policies. If the resident or his or her responsible party wishes to provide their own cooking appliance, it shall meet the facility's policies and safety standards. The cooking appliances shall be designed so that they can be disconnected and removed for resident safety or if the resident chooses not have cooking capability within his or her apartment. The cooking appliance shall have an automatic timer."

The Board took into consideration all of the written comments as well as the oral comment and voted to adopt the suggested changes to the proposed rules made by the three commenters.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process, all agencies shall conduct a review of whether a proposed rule or rule affects small business.

(1) The extent to which the rule or rules may overlap, duplicate, or conflict with other federal, state, and local governmental rules.

These rules do not overlap, duplicate, or conflict with other federal, state, or local governmental rules.

(2) Clarity, conciseness, and lack of ambiguity in the rule or rules.

These rules exhibit clarity, conciseness, and lack of ambiguity.

(3) The establishment of flexible compliance and/or reporting requirements for small businesses.

These rules do not contain reporting requirements for small businesses.

(4) The establishment of friendly schedules or deadlines for compliance and/or reporting requirements for small businesses.

These rules do not contain reporting requirements for small businesses.

(5) The consolidation or simplification of compliance or reporting requirements for small businesses.

These rules do not contain reporting requirements for small businesses.

(6) The establishment of performance standards for small businesses as opposed to design or operational standards required in the proposed rule.

These rules do not establish performance, design, or operational standards.

(7) The unnecessary creation of entry barriers or other effects that stifle entrepreneurial activity, curb innovation, or increase costs.

These rules do not create unnecessary barriers or stifle entrepreneurial activity or innovation.

STATEMENT OF ECONOMIC IMPACT TO SMALL BUSINESSES

Name of Board, Committee or Council: Board for Licensing Health Care Facilities

Rulemaking hearing date: February 8, 2017

1. **Type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, and/or directly benefit from the proposed rule:**

   These rule amendments will affect licensees and patients of the following facilities: Hospitals, Nursing Homes, Ambulatory Surgical Treatment Centers, Homes for the Aged, Assisted-Care Living Facilities, Home Care Organizations Providing Home Medical Equipment, and Home Care Organizations Providing Professional Support Services. The licensees and patients of these facilities will benefit from these amendments as the new rules will clarify definitions and procedures for these facilities.

2. **Projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record:**

   These rule amendments will not affect reporting, recordkeeping or other administrative costs.

3. **Statement of the probable effect on impacted small businesses and consumers:**

   These rule amendments should positively impact small businesses as the rules clarify rule provisions that currently result in frequent citations. Consumers should benefit from the proposed rules and the clarity they will provide as well.

4. **Description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and/or objectives of the proposed rule that may exist, and to what extent, such alternative means might be less burdensome to small business:**

   There are no less burdensome, less intrusive or less costly alternative methods of achieving the purpose or objectives of these proposed rules.

5. **Comparison of the proposed rule with any federal or state counterparts:**

   Federal: None.

   State: None.

6. **Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule.**

   These rule amendments do not provide for exemptions of small businesses.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (http://publications.tnsosfiles.com/acts/106/pub/pc1070.pdf) of the 2010 Session of the General Assembly)

The proposed rule amendments should not have a financial impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

(A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The amendment to Rule 1200-08-01-.01(24) deletes the current definition of "dietitian" and replaces it with new language.

New paragraph 1200-08-01-.01(45) adds a definition for "licensed health care professional."

The amendment to Rule 1200-08-01-.05(1) adds the term inpatient and requires every person admitted as an inpatient to be under the supervision of a physician with an unlimited license to practice as well as requiring that physician to be documented on the patient's medical record.

The amendment to Rule 1200-08-01-.05(2) deletes the current language which lists specific practitioners (dentists, podiatrists, and certified nurse midwives) and adds new language which clarifies that all licensed practitioners are allowed, under the supervision of a credentialed medical doctor or doctor of osteopath, to write orders for the care and treatment of patients if allowed to do so under the hospital bylaws.

The amendment to Rule 1200-08-01-.05(5) allow physical therapy, occupational therapy, or speech language pathology services, without an order from a physician, dentist, or podiatrist, if those services are being provided on an outpatient basis and are being provided consistent with the scope of practice of physical therapists, occupational therapists, and speech language pathologists as set forth in their respective practice acts found in Tennessee Code Annotated, Title 63, Chapters 13 and 17 as well as state that, except in emergencies, no medication or treatment shall be given or administered to any inpatient in a hospital except on the order or referral of a licensed practitioner lawfully authorized to give such an order.

The amendment to Rule 1200-08-01-.06 (9)(e) 1 and 2 clarifies the involvement of dietitians in caring for patients' dietary needs in a hospital setting and allows dietitians to order a therapeutic diet under certain conditions.

The amendment to Rule 1200-08-01-.07 deletes subparagraph (6)(e) and amends the subparagraph to require that services be provided according to a written treatment plan in accordance with the practice acts of the practitioners.

The amendment to Rule 1200-08-06-.01 deletes the term "patient abuse."

The amendment to Rule 1200-08-10-.04 (20)(b)(3) and (20)(b)(4) removes the specific items that shall be provided to patients in the Ambulatory Surgical Treatment Center (ASTC).

The amendment to Rule 1200-08-10-.11(3) adds the word "patient" between the words "each" and "case" and adds the following sentence: "The ASTC will monitor outbreaks of communicable diseases in the nearby geographical area of the facility and inform the ASTC staff of these outbreaks in order for the employee to contact their personal physician for consultation regarding their vaccination status."

The amendment to Rule 1200-08-11-.01 deletes the term "patient abuse."

The amendments to Rule 1200-08-25-.02(20) change the definition of "licensed health care professional" and change the reference found in the rules to "social worker" rather than "clinical social worker." Additionally, these amendments add a definition for "medication aide" and change the language of "secured unit" to allow egress when necessary to meet life safety requirements.

The amendment to Rule 1200-08-25-.03(9)(b)3 raises the minimum age for becoming licensed as an administrator of an assisted care living facility from eighteen (18) to twenty-one (21).

The amendment to Rule 1200-08-25-.07(5)(b) includes certified professionals and limits the duties of the "medication aide." The amendment to Rule 1200-08-25-.07(5)(c) clarifies the manner in which assisted-care living facilities should store residents' medications.

The amendment to Rule 1200-08-25-.07(5)(d) reads: "[f]acility staff shall not repackage medication and shall not administer medication from repackaging."

The amendment to Rule 1200-08-25-.07(6)(f) provides that a certified health professional can dispose of medication.

The amendment to Rule 1200-08-25-.08 removes a reference in (9)(a) to a social worker.

The amendment to Rule 1200-08-25-.10(2)(i) adds allowance for cooking appliances with certain restrictions.

The amendment to Rule 1200-08-25-.10(2)(n) removes specific references to certain types of fire extinguishers permissible under National Fire Protection Association (NFPA) 10.

The amendment to Rule 1200-08-34-.05(10) remove a reference to "Division of Mental Retardation Services (DMRS)" and replaces it with "Department of Intellectual and Developmental Disabilities (DIDD)."

(B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

None.

(C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

These rule amendments will affect licensees and patients of the following facilities: Hospitals, Nursing Homes, Ambulatory Surgical Treatment Centers, Homes for the Aged, Assisted-Care Living Facilities, and Home Care Organizations Providing Professional Support Services.

(D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule or the necessity to promulgate the rule;

None.

(E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars ($500,000), whichever is less;

These rules should not result in any increase or decrease in state or local government revenues or expenditures.

(F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Kyonzté Hughes-Toombs, Office of General Counsel, Department of Health.

(G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Kyonzté Hughes-Toombs, Office of General Counsel, Department of Health.

(H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

Office of General Counsel, Department of Health, 665 Mainstream Drive, Nashville, Tennessee 37243, (615) 741-1611, Kyonzte.Hughes-Toombs@tn.gov.

(l) Any additional information relevant to the rule proposed for continuation that the committee requests.

None.

RULES
OF
TENNESSEE DEPARTMENT OF HEALTH
BOARD FOR LICENSING HEALTH CARE FACILITIES

CHAPTER 1200-08-01
STANDARDS FOR HOSPITALS

TABLE OF CONTENTS

1200-08-01-.01 DEFINITIONS.

(1) Abuse. The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.

(2) Acceptable Plan of Correction. The Licensing Division shall approve a hospital's acceptable plan to correct deficiencies identified during an on-site survey conducted by the Survey Division or its designated representative. The plan of correction shall be a written document and shall provide, but not limited to, the following information:

(a) How the deficiency will be corrected.

(b) Who will be responsible for correcting the deficiency.

(c) The date the deficiency will be corrected.

(d) How the facility will prevent the same deficiency from re-occurring.

(3) Adult. An individual who has capacity and is at least 18 years of age.

(4) Advance Directive. An individual instruction or a written statement relating to the subsequent provision of health care for the individual, including, but not limited to, a living will or a durable power of attorney for health care.

(5) Agent. An individual designated in an advance directive for health care to make a health care decision for the individual granting the power.

(6) Board. The Tennessee Board for Licensing Health Care Facilities.

(7) Capacity. An individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision. These regulations do not affect the right of a patient to make health care decisions while having the capacity to do so. A patient shall be presumed to have capacity to make a health care decision, to give or revoke an advance directive, and to designate or disqualify a surrogate. Any person who challenges the capacity of a patient shall have the burden of proving lack of capacity.

(Rule 1200-08-01-.01, continued)

(8) Cardiopulmonary Resuscitation (CPR). The administering of any means or device to support cardiopulmonary functions in a patient, whether by mechanical devices, chest compressions, mouth-to-mouth resuscitation, cardiac massage, tracheal intubation, manual or mechanical ventilators or respirations, defibrillation, the administration of drugs and/or chemical agents intended to restore cardiac and/or respiratory functions in a patient where cardiac or respiratory arrest has occurred or is believed to be imminent.

(9) Certified Master Social Worker. A person currently certified as such by the Tennessee Board of Social Worker Certification and Licensure.

(10) Certified Nurse Practitioner. A person who is licensed as a registered nurse and has further been issued a certificate of fitness to prescribe and/or issue legend drugs by the Tennessee Board of Nursing.

(11) Certified Registered Nurse Anesthetist. A registered nurse currently licensed by the Tennessee Board of Nursing who is currently certified as such by the American Association of Nurse Anesthetists.

(12) Certified Respiratory Therapist. A person currently certified as such by the Tennessee Board of Medical Examiners' Council on Respiratory Care.

(13) Certified Respiratory Therapy Technician. A person currently certified as such by the Tennessee Board of Medical Examiners' Council on Respiratory Care.

(14) Clinical Laboratory Improvement Act (CLIA). The federal law requiring that clinical laboratories be approved by the U.S. Department of Health and Human Services, Health Care Financing Administration.

(15) Collaborative Practice. The implementation of the collaborative plan that outlines procedures for consultation and collaboration with other health care professional, e.g., licensed physicians and mid-level practitioners.

(16) Collaborative Plan. The formal written plan between the mid-level practitioners and a licensed physician.

(17) Commissioner. The Commissioner of the Tennessee Department of Health or his or her authorized representative.

(18) Competent. A patient who has capacity.

(19) Critical Access Hospital. A hospital located in a rural area, certified by the Department as being a necessary provider of health care services to residents of the area, which makes available twenty-four (24) hour emergency care; is a designated provider in a rural health network; provides not more than twenty-five (25) acute care inpatient beds for providing inpatient care not to exceed an annual average of ninety-six (96) hours, and has a quality assessment and performance improvement program and procedures for utilization review. If swing-bed approval has been granted, all twenty-five (25) beds can be used interchangeably for acute or Skilled Nursing Facility (SNF/swing-bed) level of care services.

(20) Dentist. A person currently licensed as such by the Tennessee Board of Dentistry.

(21) Department. The Tennessee Department of Health.

(22) Designated Physician. A physician designated by an individual or the individual's agent, guardian, or surrogate, to have primary responsibility for the individual's health care or, in the

(Rule 1200-08-01-.01, continued)

absence of a designation or if the designated physician is not reasonably available, a physician who undertakes such responsibility.

(23) Designation. An official finding and recognition by the Department of Health that an acute care hospital meets Tennessee State Rural Health Care Plan requirements to be a Critical Access Hospital.

~~(24) Dietitian. A person currently licensed as such by the Tennessee Board of Dietitian/Nutritionist Examiners. Persons exempt from licensure shall be registered with the American Dietetics Association pursuant to T.C.A. § 63-25-104.~~

(24) Dietitian. As used in the chapter, the term "dietitian" means:

(a) A person who is currently licensed by the Tennessee Board of Dietitian/Nutritionist Examiners as a dietitian/nutritionist; or

(b) An employee of a Tennessee hospital who is exempt from Tennessee licensure pursuant to T.C.A. § 63-25-104(b)(6) but holds the credential of Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN) from the Commission on Dietetic Registration.

(25) Do-Not-Resuscitate Order (DNR). A written order, other than a POST, not to resuscitate a patient in cardiac or respiratory arrest in accordance with accepted medical practices.

(26) Electronic Signature. The authentication of a health record document or documentation in an electronic form achieved through electronic entry of an exclusively assigned, unique identification code entered by the author of the documentation.

(27) Emancipated Minor. Any minor who is or has been married or has by court order or otherwise been freed from the care, custody and control of the minor's parents.

(28) Emergency Responder. A paid or volunteer firefighter, law enforcement officer, or other public safety official or volunteer acting within the scope of his or her proper function under law or rendering emergency care at the scene of an emergency.

(29) Graduate Registered Nurse Anesthetist. A registered nurse currently licensed in Tennessee who is a graduate of a nurse anesthesia educational program that is accredited by the American Association of Nurse Anesthetist's Council on Accreditation of Nurse Anesthesia Educational Programs and awaiting initial certification examination results, provided that initial certification is accomplished within eighteen (18) months of completion of an accredited nurse anesthesia educational program.

(30) Guardian. A judicially appointed guardian or conservator having authority to make a health care decision for an individual.

(31) Hazardous Waste. Materials whose handling, use, storage, and disposal are governed by local, state or federal regulations.

(32) Health Care. Any care, treatment, service or procedure to maintain, diagnose, treat, or otherwise affect an individual's physical or mental condition, and includes medical care as defined in T.C.A. § 32-11-103(5).

(33) Health Care Decision. Consent, refusal of consent or withdrawal of consent to health care.

(34) Health Care Decision-maker. In the case of a patient who lacks capacity, the patient's health care decision-maker is one of the following: the patient's health care agent as specified in an

(Rule 1200-08-01-.01, continued)

advance directive, the patient's court-appointed guardian or conservator with health care decision-making authority, the patient's surrogate as determined pursuant to Rule 1200-08-01-.13 or T.C.A. § 33-3-220, the designated physician pursuant to these Rules or in the case of a minor child, the person having custody or legal guardianship.

(35) Health Care Institution. A health care institution as defined in T.C.A. § 68-11-1602.

(36) Health Care Provider. A person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care in the ordinary course of business or practice of a profession.

(37) Hospital. Any institution, place, building or agency represented and held out to the general public as ready, willing and able to furnish care, accommodations, facilities and equipment for the use, in connection with services of a physician or dentist, to one (1) or more nonrelated persons who may be suffering from deformity, injury or disease or from any other condition for which nursing, medical or surgical services would be appropriate for care, diagnosis or treatment. All hospitals shall provide basic hospital functions and may provide optional services as delineated in these rules. A hospital shall be designated according to its classification and shall confine its services to those classifications described below.

(a) General Hospital. To be licensed as a general hospital, the institution shall maintain and operate organized facilities and services to accommodate one or more non-related persons for a period exceeding twenty-four (24) hours for the diagnosis, treatment or care of such persons and shall provide medical and surgical care of acute illness, injury or infirmity and obstetrical care. All diagnosis, treatment and care shall be administered by or performed under the direction of persons currently licensed to practice the healing arts in the State of Tennessee. In addition, a general hospital must specifically provide:

1. An organized staff of professional, technical and administrative personnel.

2. A laboratory with sufficient equipment and personnel necessary to perform biochemical, bacteriological, serological and parasitological tests.

3. X-ray facilities which shall include, as a minimum requirement, a complete diagnostic radiographic unit.

4. A separate surgical unit which shall include, as minimum requirements, one operating room, a sterilizing room, a scrub-up area and workroom.

5. Obstetrical facilities which shall include, as minimum requirements, one delivery room, a labor room, a newborn nursery, an isolation nursery, and patient rooms designated exclusively for obstetrical patients.

6. An emergency department in accordance with rule 1200-08-01-.07(5) of these standards and regulations.

(b) Satellite Hospital. A satellite hospital may be licensed with a parent hospital upon approval by the Board for Licensing Health Care Facilities when they are on separate premises and are operated under the same management.

(c) Chronic Disease Hospital. To be licensed as a chronic disease hospital, the institution shall be devoted exclusively to the diagnosis, treatment or care of persons needing medical, surgical or rehabilitative care for chronic or long-term illness, injury, or infirmity. The diagnosis, treatment or care shall be administered by or performed under the direction of persons currently licensed to practice the healing arts in the State of Tennessee. A chronic disease hospital shall meet the requirements for a general

(Rule 1200-08-01-.01, continued)

hospital except that obstetrical facilities are not required and, if the hospital provides no surgical services, an emergency department is not required.

(d) Orthopedic Hospital. To be licensed as an orthopedic hospital, the institution shall be devoted primarily to the diagnosis and treatment of orthopedic conditions. An orthopedic hospital shall meet the requirements for a general hospital except that obstetrical services are not required and, if the hospital provides no surgical services, an emergency department is not required.

(e) Pediatric Hospital. To be licensed as a pediatric hospital, the institution shall be devoted primarily to the diagnosis and treatment of pediatric cases and have on staff professional personnel especially qualified in the diagnosis and treatment of the diseases of children. A pediatric hospital shall meet the requirements of a general hospital except that obstetrical facilities are not required and if the hospital provides no surgical services, an emergency department is not required.

(f) Eye, Ear, Nose, and Throat Hospital or any one of these. To be licensed as an eye, ear, nose and throat hospital, the institution shall be devoted primarily to the diagnosis and treatment of the diseases of the eye, ear, nose, and throat. The hospital shall have on staff professional personnel especially qualified in the diagnosis and treatment of diseases of the eye, ear, nose and throat. An eye, ear, nose and throat hospital shall meet the requirements for a general hospital except that obstetrical facilities are not required and, if the hospital provides no surgical services, an emergency department is not required.

(g) Rehabilitation Hospital. To be licensed as a rehabilitation hospital, the institution shall be devoted primarily to the diagnosis and treatment of persons requiring rehabilitative services. A rehabilitation hospital shall meet the requirement of a general hospital except that radiology services, a surgical unit, obstetrical facilities, and an emergency department are not required.

(38) Hospitalization. The reception and care of any person for a continuous period longer than twenty-four (24) hours, for the purpose of giving advice, diagnosis, nursing service or treatment bearing on the physical health of such persons, and maternity care involving labor and delivery for any period of time.

(39) Incompetent. A patient who has been adjudicated incompetent by a court of competent jurisdiction and has not been restored to legal capacity.

(40) Individual instruction. An individual's direction concerning a health care decision for the individual.

(41) Infectious Waste. Solid or liquid wastes which contain pathogens with sufficient virulence and quantity such that exposure to the waste by a susceptible host could result in an infectious disease.

(42) Involuntary Transfer. The movement of a patient between hospitals, without the consent of the patient, the patient's legal guardian, next of kin or representative.

(43) Justified Emergency. Includes, but is not limited to, the following events/ occurrences:

(a) An influx of mass casualties;

(b) Localized and/or regional catastrophes such as storms, earthquakes, tornadoes, etc. or,

(Rule 1200-08-01-.01, continued)

(c) Epidemics or episodes of mass illness such as influenza, salmonella, etc.

(44) Licensed Clinical Social Worker. A person currently licensed as such by the Tennessee Board of Social Workers.

(45) Licensed health care professional. Any health care professional currently licensed by the State of Tennessee to practice within the scope of a regulated profession, such as a nurse practitioner, dietitian, dentist, occupational therapist, pharmacist, physical therapist, physician, physician assistant, podiatrist, psychologist, clinical social worker, speech language pathologist, and emergency service personnel.

(46)~~(45)~~ Licensed Practical Nurse. A person currently licensed as such by the Tennessee Board of Nursing.

(47)~~(46)~~ Licensee. The person or entity to whom the license is issued. The licensee is held responsible for compliance with all rules and regulations.

(48)~~(47)~~ Life Threatening Or Serious Injury. Injury requiring the patient to undergo significant additional diagnostic or treatment measures.

(49)~~(48)~~ Medical Emergency. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part, which includes labor when delivery is imminent, when there is inadequate time to effect safe transfer to another hospital prior to delivery, or when a transfer may pose a threat to the health and safety of the patient or the unborn child.

(50)~~(49)~~ Medical Record. Medical histories, records, reports, summaries, diagnoses, prognoses, records of treatment and medication ordered and given, entries, x-rays, radiology interpretations. and other written electronics, or graphic data prepared, kept, made or maintained in a facility that pertains to confinement or services rendered to patients admitted or receiving care.

(51)~~(50)~~ Medical Staff. An organized body composed of individuals appointed by the hospital governing board that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital. All members of the medical staff shall be licensed to practice in Tennessee, with the exception of interns and residents.

(52)~~(51)~~ Medically Inappropriate Treatment. Resuscitation efforts that cannot be expected either to restore cardiac or respiratory function to the patient or other medical or surgical treatments to achieve the expressed goals of the informed patient. In the case of the incompetent patient, the patient's representative expresses the goals of the patient.

(53)~~(52)~~ Member of the Professional Medical Community. A professional employed by the hospital and on the premises at the time of a voluntary delivery.

(54)~~(53)~~ Mid-Level Practitioner. Either a certified nurse practitioner or a physician assistant.

(55)~~(54)~~ Misappropriation of Patient/Resident Property. The deliberate misplacement, exploitation or wrongful, temporary or permanent use of an individual's belongings or money without the individual's consent.

(56)~~(55)~~ Neglect. The failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness; however, the withholding of authorization for or provision of

(Rule 1200-08-01-.01, continued)

medical care to any terminally ill person who has executed an irrevocable living will in accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of the living will, shall not be deemed "neglect" for purposes of these rules.

(57)~~(56)~~ N.F.P.A. The National Fire Protection Association.

(58)~~(57)~~ Nuclear Medicine Technologist. A person currently registered as such by the National Association for Nuclear Medicine Technology.

(59)~~(58)~~ Nurse Midwife. A person currently licensed by the Tennessee Board of Nursing as a registered nurse (R.N.) and qualified to deliver midwifery services or certified by the American College of Nurse-Midwives.

(60)~~(59)~~ Occupational Therapist. A person currently certified as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(61)~~(60)~~ Occupational Therapy Assistant. A person currently certified as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(62)~~(61)~~ Optometrist. A person currently licensed as such by the Tennessee Board of Optometry.

(63)~~(62)~~ Patient. Includes but is not limited to any person who is suffering from an acute or chronic illness or injury or who is crippled, convalescent or infirm, or who is in need of obstetrical, surgical, medical, nursing or supervisory care.

(64)~~(63)~~ Person. An individual, corporation, estate, trust, partnership, association, joint venture, government, governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

(65)~~(64)~~ Personally Informing. A communication by any effective means from the patient directly to a health care provider.

(66)~~(65)~~ Pharmacist. A person currently licensed as such by the Tennessee Board of Pharmacy.

(67)~~(66)~~ Physical Therapist. A person currently certified as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(68)~~(67)~~ Physical Therapy Assistant. A person currently certified as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(69)~~(68)~~ Physician. An individual authorized to practice medicine or osteopathy under Tennessee Code Annotated, Title 63, Chapters 6 or 9.

(70)~~(69)~~ Physician Assistant. A person who has graduated from a physician assistant educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant, has passed the Physician Assistant National Certifying Examination, and is currently licensed in Tennessee as a physician assistant under title 63, chapter 19.

(71)~~(70)~~ Physician Orders for Scope of Treatment or POST. Written orders that:

(a) Are on a form approved by the Board for Licensing Health Care Facilities;

(Rule 1200-08-01-.01, continued)

(b) Apply regardless of the treatment setting and that are signed as required herein by the patient's physician, physician assistant, nurse practitioner, or clinical nurse specialist; and

(c)

1. Specify whether, in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should or should not be attempted;
2. Specify other medical interventions that are to be provided or withheld; or
3. Specify both 1 and 2.

(72)~~(71)~~ Podiatrist. A person currently licensed as such by the Tennessee Board of Registration in Podiatry.

(73)~~(72)~~ Power of Attorney for Health Care. The designation of an agent to make health care decisions for the individual granting the power under T.C.A. Title 34, Chapter 6, Part 2.

(74)~~(73)~~ Psychologist. A person currently licensed as such by the Tennessee Board of Examiners in Psychology.

(75)~~(74)~~ Qualified Emergency Medical Service Personnel. Includes, but shall not be limited to, emergency medical technicians, paramedics, or other emergency services personnel, providers, or entities acting within the usual course of their professions, and other emergency responders.

(76)~~(75)~~ Radiological Technologist. A person currently registered as such by the American Society of Radiological Technologists.

(77)~~(76)~~ Reasonably Available. Readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient's health care needs. Such availability shall include, but not be limited to, availability by telephone.

(78)~~(77)~~ Registered Health Information Administrator (RHIA). A person currently registered as such by the American Health Information Management Association.

(79)~~(78)~~ Registered Health Information Technician (RHIT). A person currently accredited as such by the American Health Information Management Association.

(80)~~(79)~~ Registered Nurse. A person currently licensed as such by the Tennessee Board of Nursing.

(81)~~(80)~~ Rural Area. A county classified by the federal Office of Management and Budget (OMB) as rural, all counties, excluding Davidson, Hamilton, Knox, and Shelby, currently defined as rural in Chapter 1200-20-11 of the Tennessee Comprehensive Rules and Regulations, or an area outside of a county or part of a county previously classified as rural by the OMB and reclassified by the OMB as a metropolitan statistical area as of June 6, 2003.

(82)~~(81)~~ Satellite Hospital. A freestanding hospital licensed with a parent hospital that is on separate premises and operated under the same management.

(83)~~(82)~~ Shall or Must. Compliance is mandatory.

(84)~~(83)~~ Social Worker. A person who has at least a bachelor's degree in Social Work or related field, and preferably, two (2) years medical social work or other community based work experience.

(Rule 1200-08-01-.01, continued)

(85)~~(84)~~ Stabilize. To provide such medical treatment of the emergency medical condition as may be necessary to assure, within reasonable medical probability, that the condition will not materially deteriorate due to the transfer as determined by a physician or other qualified medical personnel when a physician is not readily available.

(86)~~(85)~~ State. A state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.

(87)~~(86)~~ Student. A person currently enrolled in a course of study that is approved by the appropriate licensing board.

(88)~~(87)~~ Supervising Health Care Provider. The designated physician or, if there is no designated physician or the designated physician is not reasonably available, the health care provider who has undertaken primary responsibility for an individual's health care.

(89)~~(88)~~ Surgical Technologist. A person who works under supervision to facilitate the safe and effective conduct of invasive surgical procedures. This individual is usually employed by a hospital, medical office, or surgical center and supervised during the surgical procedure according to institutional policy and procedure to assist in providing a safe operating room environment that maximizes patient safety by performing certain tasks including, but not limited to:

(a) Preparation of the operating room and the sterile field for surgical procedures by preparing sterile supplies, instruments, and equipment using sterile technique;

(b) Preparation of the operating room for surgical procedures by ensuring that surgical equipment is functioning properly and safely; and

(c) Passing instruments, equipment or supplies to a surgeon, sponging or suctioning an operative site, preparing and cutting suture material, holding retractors, transferring but not administering fluids or drugs, assisting in counting sponges, needles, supplies, and instruments, and performing other similar tasks as directed during a surgical procedure.

(90)~~(89)~~ Surrogate. An individual, other than a patient's agent or guardian, authorized to make a health care decision for the patient.

(91)~~(90)~~ Transfer. The movement of a patient between hospitals at the direction of a physician or other qualified medical personnel when a physician is not readily available but does not include such movement of a patient who leaves the facility against medical advice. The term does not apply to the commitment and movement of mentally ill and mentally retarded persons and does not apply to the discharge or release of a patient no longer in medical need of hospital care or to a hospital's refusal, after an appropriate medical screening, to render any medical care on the grounds that the person does not have a medical need for hospital care.

(92)~~(91)~~ Treating Health Care Provider. A health care provider who at the time is directly or indirectly involved in providing health care to the patient.

(93)~~(92)~~ Treating Physician. The physician selected by or assigned to the patient and who has the primary responsibility for the treatment and care of the patient. Where more than one physician shares such responsibility, any such person may be deemed to be the "treating physician."

(94)~~(93)~~ Voluntary Delivery. The action of a mother in leaving an unharmed infant aged seventy-two (72) hours or younger on the premises of a hospital with any hospital employee or

(Rule 1200-08-01-.01, continued)

member of the professional medical community without expressing any intention to return for such infant, and failing to visit or seek contact with such infant for a period of thirty (30) days thereafter.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 39-11-106, 68-11-202, 68-11-204, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-224, 68-11-255, 68-11-1802, 68-57-101, 68-57-102, and 68-57-105.* ***Administrative History:*** *Original rule certified June 7, 1974. Amendment filed April 3, 1974; effective May 3, 1974. Amendment filed November 30, 1984; effective December 30, 1984. Repeal and new rule filed May 22, 1986; effective June 21, 1986. Amendment filed April 26, 1996; effective July 8, 1996. Amendment filed November 30, 1999; effective February 6, 2000. Repeal, except for Paragraphs (1), (5), (8), (10), (11), (13), (16), (29) and (37) as promulgated February 6, 2000, and new rule filed March 18, 2000; effective May 30, 2000. Amendment filed April 17, 2000; effective July 1, 2000. Amendment filed September 17, 2002; effective December 1, 2002. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed April 28, 2003; effective July 12, 2003. Amendment filed August 27, 2004; effective November 10, 2004. Amendments filed September 6, 2005; effective November 20, 2005. Amendment filed February 23, 2006; effective May 9, 2006. Amendment filed February 7, 2007; effective April 23, 2007. Amendment filed February 22, 2010; effective May 23, 2010. Amendments filed March 18, 2010; effective June 16, 2010. Amendment filed January 3, 2012; effective April 2, 2012. Amendment filed March 27, 2015; effective June 25, 2015. Amendment filed April 25, 2016; effective July 24, 2016.*

1200-08-01-.02 LICENSING PROCEDURES.

(1) No person, partnership, association, corporation, or state, county or local government unit, or any division, department, board or agency thereof, shall establish, conduct, operate, or maintain in the State of Tennessee any hospital without having a license. A license shall be issued only to the applicant named and only for the premises listed in the application for licensure. Licenses are not transferable or assignable and shall expire and become invalid annually on the anniversary date of their original issuance. The license shall be conspicuously posted in the hospital.

(2) In order to make application for a license:

(a) The applicant shall submit an application on a form prepared by the department.

(b) Each applicant for a license shall pay an annual license fee based on the number of hospital beds. The fee must be submitted with the application and is not refundable.

(c) The issuance of an application form is in no way a guarantee that the completed application will be accepted or that a license will be issued by the department. Patients shall not be admitted to the hospital until a license has been issued. Applicants shall not hold themselves out to the public as being a hospital until the license has been issued. A license shall not be issued until the facility is in substantial compliance with these rules and regulations including submission of all information required by T.C.A. §68-11-206(1), or as later amended, and of all information required by the Commissioner.

(d) The applicant must prove the ability to meet the financial needs of the facility.

(e) The applicant shall not use subterfuge or other evasive means to obtain a license, such as filing for a license through a second party when an individual has been denied a license or has had a license disciplined or has attempted to avoid inspection and review process.

(f) The applicant shall allow the hospital to be inspected by a Department surveyor. In the event that deficiencies are noted, the applicant shall submit a plan of corrective action

(Rule 1200-08-01-.04, continued)

(13) The facility shall develop a concise statement of its charity care policies and shall post such statement in a place accessible to the public.

(14) Informed Consent

(a) Any hospital in which abortions, other than abortions necessary to prevent the death of the pregnant female, are performed shall conspicuously post a sign in a location defined below so as to be clearly visible to patients, which reads:

Notice: It is against the law for anyone, regardless of the person's relationship to you, to coerce you into having or to force you to have an abortion. By law, we cannot perform an abortion on you unless we have your freely given and voluntary consent. It is against the law to perform an abortion on you against your will. You have the right to contact any local or state law enforcement agency to receive protection from any actual or threatened criminal offense to coerce an abortion.

(b) The sign shall be printed in languages appropriate for the majority of clients of the hospital with lettering that is legible and that is Arial font, at least 40-point bold-faced type.

(c) A hospital in which abortions are performed that is not a private physician's office or ambulatory surgical treatment center shall post the required sign in the admissions or registration department used by patients on whom abortions are performed.

(d) A hospital shall be assessed a civil penalty by the board for licensing health care facilities of two thousand five hundred dollars ($2,500.00) for each day of violation in which:

1. The sign required above was not posted during business hours when patients or prospective patients are present; and

2. An abortion other than an abortion necessary to prevent the death of the pregnant female was performed in the hospital.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 39-15-202, 39-17-1803, 39-17-1805, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-216, 68-11-268 and 71-6-121.* ***Administrative History:*** *Original rule filed March 18, 2000; effective May 30, 2000. Amendment filed June 18, 2002; effective September 1, 2002. Amendment filed December 2, 2003; effective February 15, 2004. Amendment filed April 20, 2006; effective July 4, 2006. Amendment filed February 23, 2007; effective May 9, 2007. Amendment filed July 18, 2007; effective October 1, 2007. Amendment filed December 23, 2009; effective March 23, 2010. Amendments filed February 22, 2010; effective May 23, 2010. Amendment filed December 16, 2013; effective March 16, 2014.*

1200-08-01-.05 ADMISSIONS, DISCHARGES, AND TRANSFERS.

~~(1) Every person admitted for care or treatment to any hospital covered by these rules shall be under the supervision of a physician who holds an unlimited license to practice in Tennessee. The name of the patient's attending physician shall be recorded in the patient's medical record.~~

(1) Every person admitted for care or treatment as an inpatient to any hospital covered by these rules shall be under the supervision of a physician who holds an unlimited license to practice in Tennessee. The name of the patient's attending physician shall be recorded in the patient's medical record.

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(Rule 1200-08-01-.05, continued)

~~(2) The above does not preclude the admission of a patient to a hospital by a dentist or podiatrist or certified nurse midwife licensed to practice in Tennessee with the concurrence of a physician member of the medical staff.~~

(2) The above does not preclude the admission of a patient to a hospital by licensed health care professional, licensed to practice in Tennessee with the concurrence of a credentialed MD/DO also licensed to practice in Tennessee if admission by a category of licensed health care professionals is provided for in the medical staff bylaws. The licensed health care professional may also provide on call services to patients in the hospital if on call services for a category of licensed health care professionals is so provided for in the medical staff bylaws. The name of the attending licensed health care professional shall be recorded in the patient medical record as well as the name of the credentialed MD/DO. If a hospital allows these licensed health care professionals to admit and care for patients, as allowed by state law, the governing body and medical staff shall establish policies and bylaws, if necessary, to ensure that the requirements of 42 CFR part 482 are met.

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(3) This does not preclude qualified oral and maxillo-facial surgeons from admitting patients and completing the admission history and physical examination and assessing the medical risk of the procedure on their patients. A physician member of the medical staff is responsible for the management of medical problems.

(4) A diagnosis must be entered in the admission records of the hospital for every person admitted for care or treatment.

~~(5) Except in emergencies, no medication or treatment shall be given or administered to any patient in a hospital except on the order of a physician, dentist or podiatrist lawfully authorized to give such an order.~~

(5) Except in emergency situations, no medication or treatment shall be given or administered to any inpatient in a hospital except on the order of a physician, dentist, or podiatrist lawfully authorized to give such an order. This requirement shall not apply to physical therapy, occupational therapy or speech language pathology services being provided in an outpatient setting when the services are being provided consistent with the scope of practice of physical therapists, occupational therapists and speech language pathologists as set forth in their respective practice acts found in Tennessee Code Annotated, Title 63, Chapters 13 and 17.

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(6) The facility shall ensure that no person on the grounds of race, color, national origin, or handicap, will be excluded from participation in, be denied benefits of, or otherwise subjected to discrimination in the provision of any care or service of the facility. The facility shall protect the civil rights of residents under the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

(7) For purposes of this chapter, the requirements for signature or countersignature by a physician, dentist, podiatrist or other person responsible for signing, countersigning or authenticating an entry may be satisfied by the electronic entry by such person of a unique code assigned exclusively to him or her, or by entry of other unique electronic or mechanical symbols, provided that such person has adopted same as his or her signature in accordance with established hospital protocol or rules.

(8) The hospital must ensure continuity of care and provide an effective discharge planning process that applies to all patients. The hospital's discharge planning process, including discharge policies and procedures, must be specified in writing and must:

(Rule 1200-08-01-.05, continued)

(a) Be developed and/or supervised by a registered nurse, social worker or other appropriately qualified personnel;

(b) Begin upon admission of any patient who is likely to suffer adverse health consequences;

(c) Be provided when identified as a need by the patient, a person acting on the patient's behalf, or by the physician;

(d) Include the likelihood of a patient's capacity for self-care or the possibility of the patient returning to his or her pre-hospitalization environment;

(e) Identify the patient's continuing physical, emotional, housekeeping, transportation, social and other needs and must make arrangements to meet those needs;

(f) Be completed on a timely basis to allow for arrangement of post-hospital care and to avoid unnecessary delays in discharge;

(g) Involve the patient, the patient's family or individual acting on the patient's behalf, the attending physician, nursing and social work professionals and other appropriate staff, and must be documented in the patient's medical record; and

(h) Be conducted on an ongoing basis throughout the continuum of hospital care. Coordination of services may involve promoting communication to facilitate family support, social work, nursing care, consultation, referral or other follow-up.

(9) A discharge plan is required on every patient, even if the discharge is to home.

(10) The hospital must arrange for the initial implementation of the patient's discharge plan and must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

(11) As needed, the patient and family members or interested persons must be taught and/or counseled to prepare them for post-hospital care.

(12) The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.

(13) The governing body of each hospital must adopt transfer and acceptance policies and procedures in accordance with these rules and the provisions of T.C.A. §§ 68-11-701 through 68-11-705. These policies must include a review of all such involuntary transfers, with special emphasis on those originating in the emergency room.

(14) Transfer agreements with other health care facilities are subject to these statutory and regulatory provisions.

(15) When a hospital proceeding in compliance with these rules seeks to appropriately transfer a patient to another hospital, the proposed receiving hospital may not decline the transfer for reasons related to the patient's ability to pay or source of payment, rather than the patient's need for medical services. The determination of the availability of space at the receiving hospital may not be based on the patient's ability to pay or source of payment.

(16) Anyone arriving at a hospital and/or the emergency department of a hospital requesting or requiring an examination or treatment for a medical condition must be provided an

(Rule 1200-08-01-.05, continued)

appropriate medical screening examination within the capability of the hospital's staff to determine whether or not a medical emergency exists.

(17) The hospital must provide further medical examination and treatment as may be required to stabilize the medical emergency within the hospital's available staff and facilities. Such treatment may include, but is not limited to, the following:

(a) Establishing and assuring an adequate airway and adequate ventilation;

(b) Initiating control of hemorrhage;

(c) Stabilizing and splinting the spine or fractures;

(d) Establishing and maintaining adequate access routes for fluid administration;

(e) Initiating adequate fluid and/or blood replacement; and

(f) Determining that the patient's vital signs (including blood pressure, pulse, respiration, and urinary output, if indicated) are sufficient to sustain adequate perfusion.

(18) A hospital is deemed to meet the requirements of this section with respect to an individual if:

(a) The hospital offers to provide the further medical examination and treatment necessary but the individual, or legally responsible person acting on the individual's behalf, refuses to consent to the examination or treatment; or

(b) The hospital offers to transfer the individual to another hospital in accordance with this section but the individual, or legally responsible person acting on the individual's behalf, refuses to consent to the transfer.

(19) If a patient at a hospital has not been or cannot be stabilized within the meaning of this section, the hospital may not transfer the patient unless:

(a) The patient, or legally responsible person acting on the patient's behalf, requests that a transfer be implemented after having been given complete and accurate information about matters pertaining to the transfer decision including:

1. The medical necessity of the movement;

2. The availability of appropriate medical services at both the transferring and receiving hospitals;

3. The availability of indigent care at the hospital initiating the transfer and the facility's legal obligations, if any, to provide medical services without regard to the patient's ability to pay; and,

4. Any obligation of the hospital through its participation in medical assistance programs of the federal, state or local government to accept the medical assistance program's reimbursement as payment in full for the needed medical care.

(b) A physician, or other appropriately qualified medical personnel when a physician is not available, makes a determination based upon the reasonable risk, expected benefits to the patient, and current available information that the medical benefits reasonably expected from the provision of appropriate medical treatment at another hospital

(Rule 1200-08-01-.05, continued)

outweigh the increased risk to the individual's medical condition resulting from a transfer; and

(c) The transfer is appropriate within the meaning of this section.

(20) An appropriate transfer includes:

(a) A physician at the receiving hospital agreeing to accept transfer of the patient and to provide appropriate medical treatment;

(b) The receiving hospital having space available and personnel qualified to treat the patient;

(c) The transferring hospital providing the receiving hospital with appropriate medical records, or copies thereof, of any examination and/or treatment initiated by the transferring hospital; and

(d) The transfer being effected with qualified personnel, appropriate transportation equipment, and the use of necessary and medically appropriate life support measures as required.

(21) Transfers made pursuant to a regionalized plan for the delivery of health care services, approved by the department or other authorized governmental planning agency, are presumed to be appropriate.

(22) After an appropriate transfer has been effected, the receiving hospital may transfer the patient back to the original hospital, and the original hospital may accept the patient, if:

(a) The original receiving hospital has stabilized the medical emergency or provided treatment of the active labor and the patient no longer has a medical emergency; and

(b) The transfer is made in accordance with (21) of this section.

(23) When a hospital determines the need to exceed its licensed bed capacity upon an occurrence of a justified emergency, the following procedures must be followed:

(a) The hospital's administrator must make written notification to the Department within forty-eight (48) hours of exceeding its licensed bed capacity.

(b) The notification must include a detailed description of the emergency including:

1. Why the licensed bed capacity was exceeded, i.e., lack of hospital beds in vicinity, specialized resources only available at the facility, etc.;

2. The estimated length of time the licensed bed capacity is expected to be exceeded; and,

3. The number of admissions in excess of the facility's licensed bed capacity.

(c) As soon as the hospital returns to its licensed bed capacity, the administrator must notify the department in writing of the effective date of its return to compliance.

(d) Staff will review all notifications of excess bed capacity with the Chairman of the Board. If, upon review of the notification, department staff concurs that a justified emergency existed, staff will notify the facility in writing. A report of the occurrence will be made to the board at the next regularly scheduled meeting as information purposes only.

(Rule 1200-08-01-.05, continued)

(e) However, if department staff does not concur that a justified emergency existed, the facility will be notified in writing that a representative is required to appear at the next regularly scheduled board meeting to justify the need for exceeding its licensed bed capacity.

(24) Infant Abandonment.

(a) Any hospital shall receive possession of any newborn infant left on hospital premises with any hospital employee or member of the professional medical community, if the infant:

1. Was born within the preceding seventy-two (72) hour period, as determined within a reasonable degree of medical certainty;

2. Is left in an unharmed condition; and

3. Is voluntarily left by a person who purported to be the child's mother and who did not express an intention of returning for the infant.

(b) The hospital, any hospital employee and any member of the professional medical community at such hospital shall inquire whenever possible about the medical history of the mother or newborn and whenever possible shall seek the identity of the mother, infant, or the father of the infant. The hospital shall also inform the mother that she is not required to respond, but that such information will facilitate the adoption of the child. Any information obtained concerning the identity of the mother, infant or other parent shall be kept confidential and may only be disclosed to the Department of Children's Services. The hospital may provide the parent contact information regarding relevant social service agencies, shall provide the mother the name, address and phone number of the department contact person, and shall encourage the mother to involve the Department of Children's Services in the relinquishment of the infant. If practicable, the hospital shall also provide the mother with both orally delivered and written information concerning the requirements of these rules relating to recovery of the child and abandonment of the child.

(c) The hospital, any hospital employee and any member of the professional medical community at such hospital shall perform any act necessary to protect the physical health or safety of the child.

(d) As soon as reasonably possible, and no later than twenty-four (24) hours after receiving a newborn infant, the hospital shall contact the Department of Children's Services, but shall not do so before the mother leaves the hospital premises. Upon receipt of notification, the department shall immediately assume care, custody and control of the infant.

(e) Notwithstanding any provision of law to the contrary, any hospital, any hospital employee and any member of the professional medical community shall be immune from any criminal or civil liability for damages as a result of any actions taken pursuant to the requirements of these rules, and no lawsuit shall be predicated thereon; provided, however, that nothing in these rules shall be construed to abrogate any existing standard of care for medical treatment or to preclude a cause of action based upon violation of such existing standard of care for medical treatment.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, and 68-11-255.* ***Administrative History:*** *Original rule filed March 18, 2000; effective May 30, 2000. Amendment filed April 17, 2000; effective July 1, 2000. Amendment filed September 17, 2002; effective December 1, 2002.*

1200-08-01-.06 BASIC HOSPITAL FUNCTIONS.

(1) Performance Improvement.

(a) The hospital must ensure that there is an effective, hospital-wide performance improvement program to evaluate and continually improve patient care and performance of the organization.

(b) The performance improvement program must be ongoing and have a written plan of implementation which assures that:

1. All organized services including services furnished by a contractor, are evaluated (all departments including engineering, housekeeping, and accounting need to show evidence of process improvement.);

2. Nosocomial infections and medication therapy are evaluated;

3. All medical and surgical services performed in the hospital are evaluated as to the appropriateness of diagnosis and treatment;

4. The competency of all staff is evaluated at least annually; and

5. The facility shall develop and implement a system for measuring improvements in adherence to the hand hygiene program, central venous catheter insertion process, and influenza vaccination program.

(c) The hospital must have an ongoing plan, consistent with available community and hospital resources, to provide or make available social work, psychological, and educational services to meet the medically-related needs of its patients which assures that:

1. Discharge planning is initiated in a timely manner; and

2. Patients, along with their necessary medical information, are transferred or referred to appropriate facilities, agencies or outpatient services, as needed, for follow-up or ancillary care.

(d) The hospital must develop and implement plans for improvement to address deficiencies identified by the performance improvement program and must document the outcome of the remedial action.

(e) The hospital must demonstrate that the appropriate governing board or board committee is regularly apprised of process improvement activities, including identified deficiencies and the outcomes of remedial action.

(2) Medical Staff.

(a) The hospital shall have an organized medical staff operating under bylaws adopted by the medical staff and approved by the governing body, to facilitate the medical staff's responsibility in working toward improvement of the quality of patient care.

(b) The hospital and medical staff bylaws shall contain procedures, governing decisions or recommendations of appropriate authorities concerning the granting, revocation, suspension, and renewal of medical staff appointments, reappointments, and/or delineation of privileges. At a minimum, such procedures shall include the following

(Rule 1200-08-01-.06, continued)

elements: A procedure for appeal and hearing by the governing body or other designated committee if the applicant or medical staff feels the decision is unfair or wrong.

(c) The governing body shall be responsible for appointing medical staff and for delineating privileges. Criteria for appointment and delineation of privileges shall be clearly defined and included in the medical staff bylaws, and related to standards of patient care, patient welfare, the objectives of the institution or the character or competency of the individual practitioner. Independent patient admission privileges shall only be granted to currently licensed doctors of medicine, osteopathy, podiatry, or dentistry.

(d) The medical staff must adopt and enforce bylaws to effectively carry out its responsibilities and the bylaws must:

1. Be approved by the governing body;

2. Include a statement of the duties and privileges of each category of medical staff;

3. Describe the organization of the medical staff;

4. Describe the qualifications to be met by a candidate in order for the medical staff to recommend that the candidate be appointed by the governing body;

5. Include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges; and

6. Include provisions for medical staff appointments granting active, associate, or courtesy medical staff membership, and/or provisions for the granting of clinical privileges. Such individuals must practice within the scope of their current Tennessee license, and the overall care of each patient must be under the supervision of a physician member of the medical staff.

(e) To be eligible for staff membership, an applicant must be a graduate of an approved program of medicine, dentistry, osteopathy, podiatry, optometry, psychology, or nurse-midwifery, currently licensed in Tennessee, competent in his or her respective field, and worthy in character and in matters of professional ethics.

(f) The medical staff shall be composed of currently licensed doctors of medicine, osteopathy, dentistry, and podiatry and may include optometrists, psychologists, and nurse-midwives. The medical staff must:

1. Periodically conduct appraisals of its members;

2. Examine the credentials of candidates for medical staff membership and make recommendations to the hospital on the appointment of the candidates; and

3. Participate actively in the hospital's process improvement plan implementation for the improvement of patient care delivery plans.

(g) The medical staff must be structured in a manner approved by the hospital or its governing body, well organized, and accountable to the hospital for the quality of the medical care provided to the patient. Disciplinary action involving medical staff taken by the hospital shall be reported to the appropriate licensing board or professional society.

(Rule 1200-08-01-.06, continued)

(h) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.

(i) The responsibility for organization and conduct of the medical staff must be assigned only to an individual doctor of medicine or osteopathy, or a doctor of dental surgery or dental medicine.

(j) All physicians and non-employee medical personnel working in the hospital must adhere to the policies and procedures of the hospital. The chief executive officer or his or her designee shall provide for the adequate supervision and evaluation of the clinical activities of non-employee medical personnel which occur within the responsibility of the medical staff service.

(3) Infection Control.

(a) The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active performance improvement program for the prevention, control, and investigation of infections and communicable diseases.

(b) The chief executive officer or administrator shall assure that an infection control committee including members of the medical staff, nursing staff and administrative staff develop guidelines and techniques for the prevention, surveillance, control and reporting of hospital infections. Duties of the committee shall include the establishment of:

1. Written infection control policies;

2. Techniques and systems for identifying, reporting, investigating and controlling infections in the hospital;

3. Written procedures governing the use of aseptic techniques and procedures in all areas of the hospital, including adoption of a standardized central venous catheter insertion process which shall contain these key components:

(i) Hand hygiene (as defined in 1200-08-01-.06(3)(g));

(ii) Maximal barrier precautions to include the use of sterile gowns, gloves, mask and hat, and large drape on patient;

(iii) Chlorhexidine skin antisepsis;

(iv) Optimal site selection;

(v) Daily review of line necessity; and

(vi) Development and utilization of a procedure checklist;

4. Written procedures concerning food handling, laundry practices, disposal of environmental and patient wastes, traffic control and visiting rules in high risk areas, sources of air pollution, and routine culturing of autoclaves and sterilizers;

5. A log of incidents related to infectious and communicable diseases;

6. A method of control used in relation to the sterilization of supplies and water, and a written policy addressing reprocessing of sterile supplies;

7. Formal provisions to educate and orient all appropriate personnel in the practice of aseptic techniques such as handwashing and scrubbing practices, proper grooming, masking and dressing care techniques, disinfecting and sterilizing techniques, and the handling and storage of patient care equipment and supplies; and

8. Continuing education provided for all hospital personnel on the cause, effect, transmission, prevention, and elimination of infections, as evidenced by front line employees verbalizing understanding of basic techniques.

(c) The administrative staff shall ensure the hospital prepares, and has readily available on site, an Infection Control Risk Assessment for any renovation or construction within existing hospitals. Components of the Infection Control Risk Assessment may include, but are not limited to, identification of the area to be renovated or constructed, patient risk groups that will potentially be affected, precautions to be implemented, utility services subject to outages, risk of water damage, containment measures, work hours for project, management of traffic flow, housekeeping, barriers, debris removal, plans for air sampling during or following project, anticipated noise or vibration generated during project.

(d) The chief executive officer, the medical staff and the chief nursing officer must ensure that the hospitalwide performance improvement program and training programs address problems identified by the infection control committee and must be responsible for the implementation of successful corrective action plans in affected problem areas.

(e) The facility shall develop policies and procedures for testing a patient's blood for the presence of the hepatitis B virus and the HIV (AIDS) virus in the event that an employee of the facility, a student studying at the facility, or other health care provider rendering services at the facility is exposed to a patient's blood or other body fluid. The testing shall be performed at no charge to the patient, and the test results shall be confidential.

(f) A Hospital shall have an annual influenza vaccination program which shall include at least:

1. The offer of influenza vaccination to all staff and independent practitioners at no cost to the person or acceptance of documented evidence of vaccination from another vaccine source or facility. The Hospital will encourage all staff and independent practitioners to obtain an influenza vaccination;

2. A signed declination statement on record from all who refuse the influenza vaccination for reasons other than medical contraindications (a sample form is available at http://tennessee.gov/health/topic/hcf-provider);

3. Education of all employees about the following:

   (i) Flu vaccination,

   (ii) Non-vaccine control measures, and

   (iii) The diagnosis, transmission, and potential impact of influenza;

4. An annual evaluation of the influenza vaccination program and reasons for non-participation; and

(Rule 1200-08-01-.06, continued)

5. A statement that the requirements to complete vaccinations or declination statements shall be suspended by the administrator in the event of a vaccine shortage as declared by the Commissioner or the Commissioner's designee.

(g) All hospitals shall each year from October 1 through March 1 offer the immunization for influenza and pneumococcal diseases to any inpatient who is sixty-five (65) years of age or older prior to discharging. This condition is subject to the availability of the vaccine.

(h) The facility and its employees shall adopt and utilize standard precautions (per CDC) for preventing transmission of infections, HIV, and communicable diseases, including adherence to a hand hygiene program which shall include:

1. Use of alcohol-based hand rubs or use of non-antimicrobial or antimicrobial soap and water before and after each patient contact if hands are not visibly soiled;

2. Use of gloves during each patient contact with blood or where other potentially infectious materials, mucous membranes, and non-intact skin could occur and gloves changed before and after each patient contact;

3. Use of either a non-antimicrobial soap and water or an antimicrobial soap and water for visibly soiled hands; and

4. Health care worker education programs which may include:

(i) Types of patient care activities that can result in hand contamination;

(ii) Advantages and disadvantages of various methods used to clean hands;

(iii) Potential risks of health care workers' colonization or infection caused by organisms acquired from patients; and

(iv) Morbidity, mortality, and costs associated with health care associated infections.

(i) All hospitals shall adopt appropriate policies regarding the testing of patients and staff for human immunodeficiency virus (HIV) and any other identified causative agent of acquired immune deficiency syndrome.

(j) Each department of the hospital performing decontamination and sterilization activities must develop policies and procedures in accordance with the current editions of the CDC guidelines for "Prevention and Control of Nosocomial Diseases" and "Isolation in Hospitals".

(k) The central sterile supply area(s) shall be supervised by an employee, qualified by education and/or experience with a basic knowledge of bacteriology and sterilization principles, who is responsible for developing and implementing written policies and procedures for the daily operation of the central sterile supply area, including:

1. Receiving, decontaminating, cleaning, preparing, and disinfecting or sterilizing reusable items;

2. Assembling, wrapping, removal of outer shipping cartons, storage, distribution, and quality control of sterile equipment and medical supplies;

(Rule 1200-08-01-.06, continued)

3. Proper utilization of sterilization process monitors, including temperature and pressure recordings, and use and frequency of appropriate chemical indicator or bacteriological spore tests for all sterilizers; and

4. Provisions for maintenance of package integrity and designation of event-related shelf life for hospital-sterilized and commercially prepared supplies;

5. Procedures for recall and disposal or reprocessing of sterile supplies; and

6. Procedures for emergency collection and disposition of supplies and the timely notification of attending physicians, general medical staff, administration and the hospital's risk management program when special warnings have been issued or when warranted by the hospital's performance improvement process.

(l) Precautions shall be taken to prevent the contamination of sterile supplies by soiled supplies. Sterile supplies shall be packaged and stored in a manner that protects the sterility of the contents. Sterile supplies may not be stored in their outermost shipping carton. This would include both hospital and commercially prepared supplies. Decontamination and preparation areas shall be separated.

(m) Space and facilities for housekeeping equipment and supply storage shall be provided in each hospital service area. Storage for bulk supplies and equipment shall be located away from patient care areas. Storage shall not be allowed in the outermost shipping carton. The building shall be kept in good repair, clean, sanitary and safe at all times.

(n) The hospital shall appoint a housekeeping supervisor who is qualified for the position by education, training and experience. The housekeeping supervisor shall be responsible for:

1. Organizing and coordinating the hospital's housekeeping service;

2. Acquiring and storing sufficient housekeeping supplies and equipment for hospital maintenance;

3. Assuring the clean and sanitary condition of the hospital to provide a safe and hygienic environment for patients and staff. Cleaning shall be accomplished in accordance with the infection control rules and regulations herein and hospital policy; and

4. Verifying regular continuing education and competency for basic housekeeping principles.

(o) Laundry facilities located in the hospital shall:

1. Be equipped with an area for receiving, processing, storing and distributing clean linen;

2. Be located in an area that does not require transportation for storage of soiled or contaminated linen through food preparation, storage or dining areas;

3. Provide space for storage of clean linen within nursing units and for bulk storage within clean areas of the hospital. Linen may not be stored in cardboard containers or other containers which offer housing for bugs; and,

(Rule 1200-08-01-.06, continued)

4. Provide carts, bags or other acceptable containers appropriately marked to identify those used for soiled linen and those used for clean linen to prevent dual utilization of the equipment and cross contamination.

(p) The hospital shall appoint a laundry service supervisor who is qualified for the position by education, training and experience. The laundry service supervisor shall be responsible for:

1. Establishing a laundry service, either within the hospital or by contract, that provides the hospital with sufficient clean, sanitary linen at all times;

2. Knowing and enforcing infection control rules and regulations for the laundry service;

3. Assuring the collection, packaging, transportation and storage of soiled, contaminated, and clean linen is in accordance with all applicable infection control rules, regulations and procedures;

4. Assuring that a contract laundry service complies with all applicable infection control rules, regulations and procedures; and,

5. Conducting periodic inspections of any contract laundry facility.

(q) The physical environment of the facility shall be maintained in a safe, clean and sanitary manner.

1. Any condition on the hospital site conducive to the harboring or breeding of insects, rodents or other vermin shall be prohibited. Chemical substances of a poisonous nature used to control or eliminate vermin shall be properly identified. Such substances shall not be stored with or near food or medications.

2. Cats, dogs or other animals shall not be allowed in any part of the hospital except for specially trained animals for the handicapped and except as addressed by facility policy for pet therapy programs. The facility shall designate in its policies and procedures those areas where animals will be excluded. The areas designated shall be determined based upon an assessment of the facility performed by medically trained personnel.

3. A bed complete with mattress and pillow shall be provided. In addition, patient units shall be provided with at least one chair, a bedside table, an over bed tray and adequate storage space for toilet articles, clothing and personal belongings.

4. Individual wash cloths, towels and bed linens must be provided for each patient. Linen shall not be interchanged from patient to patient until it has been properly laundered.

5. Bath basin water service, emesis basin, bedpan and urinal shall be individually provided.

6. Water pitchers, glasses, thermometers, emesis basins, douche apparatus, enema apparatus, urinals, mouthwash cups, bedpans and similar items of equipment coming into intimate contact with patients shall be disinfected or sterilized after each use unless individual equipment for each is provided and then sterilized or disinfected between patients and as often as necessary to maintain them in a clean and sanitary condition. Single use, patient disposable items are acceptable but shall not be reused.

(Rule 1200-08-01-.06, continued)

(4) Nursing Services.

(a) The hospital must have an organized nursing service that provides twenty-four (24) hour nursing services furnished or supervised by a registered nurse, and have a licensed practical nurse or registered nurse on duty at all times.

(b) The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The chief nursing officer must be a licensed registered nurse who is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital.

(c) The nursing service must have adequate numbers of licensed registered nurses, licensed practical nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient.

(d) There must be a procedure to ensure that hospital nursing personnel for whom licensure is required have valid and current licenses.

(e) A registered nurse must assess, supervise and evaluate the nursing care for each patient.

(f) The hospital must ensure that an appropriate individualized plan of care is available for each patient.

(g) A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. All nursing personnel assigned to special care units shall have specialized training and a program in-service and continuing education commensurate with the duties and responsibilities of the individual. All training shall be documented for each individual so employed, along with documentation of annual competency skills.

(h) A registered nurse may make the actual determination and pronouncement of death under the following circumstances:

1. the deceased was a patient at a hospital as defined by T.C.A. § 68-11-201(27);

2. death was anticipated, and the attending physician has agreed in writing to sign the death certificate. Such agreement by the attending physician must be present with the deceased at the place of death;

3. the nurse is licensed by the state; and

4. the nurse is employed by the hospital providing services to the deceased.

(i) Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The chief nursing officer must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing service. Annual competency and skill documentation must be demonstrated on these individuals just as employees, if they perform clinical activities.

(Rule 1200-08-01-.06, continued)

(j) All drugs, devices and related materials must be administered by, or under the supervision of, nursing or other personnel in accordance with federal and state laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.

(k) All orders for drugs, devices and related materials must be in writing and signed by the practitioner or practitioners responsible for the care of the patient. Electronic and computer-generated records and signature entries are acceptable. When telephone or oral orders must be used, they must be:

1. Accepted only by personnel that are authorized to do so by the medical staff policies and procedures, consistent with federal and state law; and

2. Signed or initialed by the prescribing practitioner according to hospital policy.

(l) Blood transfusions and intravenous medications must be administered in accordance with state law and approved medical staff policies and procedures.

(m) There must be a hospital procedure for reporting transfusion reactions, adverse drug reactions, and errors in administration of drugs.

(5) Medical Records.

(a) The hospital shall comply with the Tennessee Medical Records Act, T.C.A. § 68-11-301, et seq. A hospital shall transfer copies of patient medical records in a timely manner to requesting practitioners and facilities.

(b) The hospital must have a medical record service that has administrative responsibility for medical records. The service shall be supervised by a Registered Health Information Administrator (RHIA), a Registered Health Information Technician (RHIT), or a person qualified by work experience. A medical record must be maintained for every individual evaluated or treated in the hospital.

(c) 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.

(d) The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurate, 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.

(e) All medical records, either written, electronic, graphic or otherwise acceptable form, must be retained in their original or legally reproduced form for a minimum period of at least ten (10) years, or for the period of minority plus one year for newborns, after which such records may be destroyed. Records destruction shall be accomplished by burning, shredding or other effective method in keeping with the confidential nature of its contents. The destruction of records must be made in the ordinary course of business, must be documented and in accordance with the hospital's policies and procedures, and no record may be destroyed on an individual basis.

(f) When a hospital closes with no plans of reopening, an authorized representative of the hospital may request final storage or disposition of the hospital's medical records by the department. Upon transfer to the department, the hospital relinquishes all control over

(Rule 1200-08-01-.06, continued)

final storage of the records in the files of the Tennessee Department of Finance and Administration and the files shall become property of the State of Tennessee.

(g) The hospital must have a system of coding and indexing medical records. The system must allow for timely retrieval by diagnosis and procedure.

(h) The hospital must have a procedure for ensuring the confidentiality of patient records. Information from or copies of records may be released only to authorized individuals, and the hospital must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released by the hospital only in accordance with federal and state laws, court orders or subpoenas.

(i) The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

(j) All entries must be legible, complete, dated and authenticated according to hospital policy.

(k) All records must document the following:

1. Evidence of a physical examination, including a health history, performed and/or updated no more than forty-five (45) days prior to admission or within forty-eight (48) hours following admission;

2. Admitting diagnosis;

3. Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient;

4. Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia;

5. Properly executed informed consent forms for procedures and treatments specified by hospital policy, or by federal or state law if applicable, as requiring written patient consent;

6. All practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient's condition;

7. Discharge summary with outcome of hospitalization, disposition of case and plan for follow-up care; and

8. Final diagnosis with completion of medical records within thirty (30) days following discharge.

(l) Electronic and computer-generated records and signature entries are acceptable.

(6) Pharmaceutical Services.

(a) The hospital must have pharmaceutical services that meet the needs of the patients and are in accordance with the Tennessee Board of Pharmacy statutes and regulations. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.

(Rule 1200-08-01-.06, continued)

(b) A full-time, part-time or consulting pharmacist must be responsible for developing, supervising and coordinating all the activities of the pharmacy services.

(c) Current and accurate records must be kept of receipt and disposition of all scheduled drugs.

(d) Adverse drug events, both adverse reactions and medication errors, shall be reported according to established guidelines to the hospital performance improvement/risk management program and as appropriate to physicians, the hospital governing body and regulatory agencies.

(e) Abuses and losses of controlled substances must be reported, in accordance with federal and state laws, to the individual responsible for the pharmaceutical service, and to the chief executive officer, as appropriate.

(f) Current reference materials relating to drug interactions and information of drug therapy, side effects, toxicology, dosage, indications for use, and routes of administration must be available to the professional staff in the pharmacy and in areas where medication is administered.

(g) Any unused portions of prescriptions shall be either turned over to the patient only on a written authorization including directions by the physician, or returned to the pharmacy for proper disposition by the pharmacist.

(h) Whenever patients bring drugs into an institution, such drugs shall not be administered unless they can be identified and ordered to be given by a physician.

(7) Radiologic Services.

(a) The hospital must maintain, or have available, diagnostic radiologic services according to the needs of the patients. If therapeutic services are also provided, they, as well as the diagnostic services, must meet professionally approved standards for safety and personnel qualifications.

(b) The radiologic services must be free from hazards for patients and personnel.

(c) Patients, employees and the general public shall be provided protection from radiation in accordance with "State Regulations for Protection Against Radiation". All radiation producing equipment shall be registered and all radioactive material shall be licensed by the Division of Radiological Health of the Tennessee Department of Environment and Conservation.

(d) Periodic inspections of equipment must be made and hazards identified must be promptly corrected.

(e) Radiologic services must be provided only on the order of practitioners with clinical privileges or of other practitioners authorized by the medical staff and the governing body to order the services.

(f) X-ray personnel shall be qualified by education, training and experience for the type of service rendered.

(g) All x-ray equipment must be registered with the Tennessee Department of Environment and Conservation, Division of Radiological Health.

(Rule 1200-08-01-.06, continued)

(h) X-rays shall be retained for four (4) years and may be retired thereafter provided that a signed interpretation by a radiologist is maintained in the patient's record under T.C.A. § 68-11-305.

(i) Patients must not be left unattended in pre and post radiology areas.

(8) Laboratory Services.

(a) The hospital must maintain, or have available, either directly or through a contractual agreement, adequate laboratory services to meet the needs of its patients. The hospital must ensure that all laboratory services provided to its patients are performed in a facility licensed in accordance with the Tennessee Medical Laboratory Act. All technical laboratory staff shall be licensed in accordance with the TMLA and shall be qualified by education, training and experience for the type of services rendered.

(b) Emergency laboratory services must be available 24 hours a day.

(c) A written description of services provided must be available to the medical staff.

(d) The laboratory must make provision for proper receipt and reporting of tissue specimens.

(e) The medical staff and a pathologist must determine which tissue specimens require a macroscopic (gross) examination and which require both macroscopic and microscopic examination.

(f) Laboratory services must be provided in keeping with services rendered by the hospital. This shall include suitable arrangements for blood and plasma at all times. Written policies and procedures shall be developed in concert with the Standards of American Association of Blood Banks. Documentation and record keeping shall be maintained for tracking and performance monitoring.

(9) Food and Dietetic Services.

(a) The hospital must have organized dietary services that are directed and staffed by adequate qualified personnel. A hospital may contract with an outside food management company if the company has a dietitian who serves the hospital on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment. If an outside contract is utilized for management of its dietary services, the hospital shall designate a full-time employee to be responsible for the overall management of the services.

(b) The hospital must designate a person, either directly or by contractual agreement, to serve as the food and dietetic services director with responsibility for the daily management of the dietary services. The food and dietetic services director shall be:

1. A qualified dietitian; or,

2. A graduate of a dietetic technician or dietetic assistant training program, correspondence or classroom, approved by the American Dietetic Association; or,

3. An individual who has successfully completed in-person or online coursework that provided ninety (90) or more hours of classroom instruction in food service

(Rule 1200-08-01-.06, continued)

supervision. If the course has not been completed, this person shall be enrolled in a course and making satisfactory progress for completion within the time limit specified by the course requirement; or,

4. An individual who is a certified dietary manager (CDM), or certified food protection professional (CFPP); or,

5. A current or former member of the U.S. military who has graduated from an approved military dietary manager training program.

(c) There must be a qualified dietitian, full time, part-time, or on a consultant basis who is responsible for the development and implementation of a nutrition care process to meet the needs of patients for health maintenance, disease prevention and, when necessary, medical nutrition therapy to treat an illness, injury or condition. Medical nutrition therapy includes assessment of the nutritional status of the patient and treatment through diet therapy, counseling and/or use of specialized nutrition supplements.

(d) There must be sufficient administrative and technical personnel competent in their respective duties.

(e) Menus must meet the needs of the patients.

~~1. Therapeutic diets must be prescribed by the practitioner or practitioners responsible for the care of the patients.~~

1. Individual patient nutritional needs must be met in accordance with recognized dietary practices.

~~2. Nutritional needs must be met in accordance with recognized dietary practices and in accordance with orders of the practitioners or practitioners responsible for the care of the patients.~~

2. All patient diets, including therapeutic diets, must be ordered by a practitioner responsible for the care of the patient, or by a qualified dietitian to whom the physician who chairs the hospital's medical executive committee has referred this task. The medical staff and hospital's board of trustees shall decide the extent of ordering privileges that a qualified dietitian shall have and a mechanism to ensure that order writing by a qualified dietitian is coordinated with the responsible practitioner's care of the patient and complies with Tennessee law governing dietitians.

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3. A current therapeutic diet manual approved by the dietitian and medical staff must be readily available to all medical, nursing, and food service personnel.

(f) Education programs, including orientation, on-the-job training, inservice education, and continuing education programs shall be offered to dietetic services personnel on a regular basis. Programs shall include instruction in personal hygiene, proper inspection, handling, preparation and serving of food and equipment.

(g) A minimum of three (3) meals in each twenty-four (24) hour period shall be served. A supplemental night meal shall be served if more than fourteen (14) hours lapse between supper and breakfast. Additional nourishment shall be provided to patients with special dietary needs.

(h) All food shall be from sources approved or considered satisfactory by the department and shall be clean, wholesome, free from spoilage, free from adulteration and

(Rule 1200-08-01-.06, continued)

misbranding and safe for human consumption. No food which has been processed in a place other than a commercial food processing establishment shall be used.

(i) Food shall be protected from sources of contamination whether in storage or while being prepared, served and/or transported. Perishable foods shall be stored at such temperatures as to prevent spoilage. Potentially hazardous foods shall be maintained at safe temperatures as defined in the current "U.S. Public Health Service Food Service Sanitation Manual".

(j) Written policies and procedures shall be followed concerning the scope of food services in accordance with the current edition of the "U.S. Public Health Service Recommended Ordinance and Code Regulating Eating and Drinking Establishments" and the current "U.S. Public Health Service Sanitation Manual" should be used as a guide to food sanitation.

(10) Critical Access Hospital.

(a) Every patient shall be under the care of a physician or under the care of a mid-level practitioner supervised by a physician.

(b) Whenever a patient is admitted to the facility by a mid-level practitioner, the supervising physician shall be notified of that fact, by phone or otherwise, and within 24 hours the supervising physician shall examine the patient or before discharge if discharged within 24 hours, and a plan of care shall be placed in the patient's chart, unless the patient is transferred to a higher level of care within 24 hours.

(c) A physician, a mid-level practitioner or a registered nurse shall be on duty and physically available in the facility when there are inpatients.

(d) A physician on staff shall:

1. Provide medical direction to the facility's health care activities and consultation for non-physician health care providers.

2. In conjunction with the mid-level practitioner staff members, participate in developing, executing, and periodically reviewing the facility's written policies and the services provided to patients.

3. Review and sign the records of each patient admitted and treated by a practitioner no later than fifteen (15) days after the patient's discharge from the facility.

4. Provide health care services to the patients in the facility, whenever needed and requested.

5. Prepare guidelines for the medical management of health problems, including conditions requiring medical consultation and/or patient referral.

6. At intervals no more than two (2) weeks apart, be physically present in the facility for a sufficient time to provide medical direction, medical care services, and staff consultation as required.

7. When not physically present in the facility, either be available through direct telecommunication for consultation and assistance with medical emergencies and patient referral, or ensure that another physician is available for this purpose.

(Rule 1200-08-01-.06, continued)

8. The physical site visit for a given two week period is not required if, during that period, no inpatients have been treated in the facility.

(e) A mid-level practitioner on staff shall:

1. Participate in the development, execution, and periodic review of the guidelines and written policies governing treatment in the facility.

2. Participate with a physician in a review of each patient's health records.

3. Provide health care services to patients according to the facility's policies.

4. Arrange for or refer patients to needed services that are not provided at the facility.

5. Assure that adequate patient health records are maintained and transferred as necessary when a patient is referred.

(f) The Critical Access Hospital, at a minimum, shall provide basic laboratory services essential to the immediate diagnosis and treatment of patients, including:

1. Chemical examinations of urine stick or tablet methods, or both (including urine ketoses);

2. Microscopic examinations of urine sediment;

3. Hemoglobin or hematocrit;

4. Blood sugar;

5. Gram stain;

6. Examination of stool specimens for occult blood;

7. Pregnancy test;

8. Primary culturing for transmittal to a CLIA certified laboratory;

9. Sediment rate; and,

10. CBC.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-3-511, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed March 18, 2000; effective May 30, 2000. Amendment filed December 2, 2003; effective February 15, 2004. Amendment filed May 24, 2004; effective August 7, 2004. Amendment filed September 6, 2005; effective November 20, 2005. Amendment filed July 18, 2007; effective October 1, 2007. Amendment filed December 23, 2009; effective March 23, 2010. Amendment filed March 18, 2010; effective June 16, 2010. Amendment filed December 16, 2013; effective March 16, 2014. Amendments filed July 18, 2016; effective October 16, 2016.*

1200-08-01-.07 OPTIONAL HOSPITAL SERVICES.

(1) Surgical Services.

(Rule 1200-08-01-.07, continued)

(a) If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered, the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

(b) The organization of the surgical services must be appropriate to the scope of the services offered.

(c) The operating rooms must be supervised by an experienced registered nurse or a doctor of medicine or osteopathy.

(d) A hospital may use scrub nurses in its operating rooms. For the purposes of this rule, a "scrub nurse" is defined as a registered nurse or either a licensed practical nurse (LPN) or a surgical technologist (operating room technician) supervised by a registered nurse who works directly with a surgeon within the sterile field, passing instruments, sponges, and other items needed during the procedure and who scrubs his or her hands and arms with special disinfecting soap and wears surgical gowns, caps, eyewear, and gloves, when appropriate.

(e) Qualified registered nurses may perform circulating duties in the operating room. In accordance with applicable state laws and approved medical staff policies and procedures, LPNs and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies.

(f) Surgical privileges must be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The surgical service must maintain a roster of practitioners specifying the surgical privileges of each practitioner.

(g) Surgical services must be consistent with needs and resources. Policies covering surgical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care.

(h) Surgical technologists must:

1. Hold current national certification established by the Liaison Council on Certification for the Surgical Technologist (LCC-ST); or

2. Have completed a program for surgical technology accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP); or

3. Have completed an appropriate training program for surgical technologists in the armed forces or at a CAAHEP accredited hospital or CAAHEP accredited ambulatory surgical treatment center; or

4. Successfully complete the surgical technologists LCC-ST certifying exam; or

5. Provide sufficient evidence that, prior to May 21, 2007, the person was at any time employed as a surgical technologist for not less than eighteen (18) months in the three (3) years preceding May 21, 2007 in a hospital, medical office, surgery center, or an accredited school of surgical technology; or has begun the appropriate training to be a surgical technologist prior to May 21, 2007, provided that such training is completed within three (3) years of May 21, 2007.

(i) A hospital can petition the director of health care facilities of the department for a waiver from the provisions of 1200-08-01-.07(1)(h) if they are unable to employ a sufficient

(Rule 1200-08-01-.07, continued)

number of surgical technologists who meet the requirements. The facility shall demonstrate to the director that a diligent and thorough effort has been made to employ surgical technologist who meet the requirements. The director shall refuse to grant a waiver upon finding that a diligent and thorough effort has not been made. A waiver shall exempt a facility from meeting the requirements for not more than nine (9) months. Additional waivers may be granted, but all exemptions greater than twelve (12) months shall be approved by the Board for Licensing Health Care Facilities.

(j) Surgical technologists shall demonstrate continued competence in order to perform their professional duties in surgical technology. The employer shall maintain evidence of the continued competence of such individuals. Continued competence activities may include but are not limited to continuing education, in-service training, or certification renewal. Persons qualified to be employed as surgical technologists shall complete fifteen (15) hours of continuing education or contact hours annually. Current certification by the National Board of Surgical Technology and Surgical Assisting shall satisfy this requirement.

(k) There must be a complete history and physical work-up in the chart of every patient prior to surgery, except in emergencies. If the history has been dictated, but not yet recorded in the patient's chart, there must be a statement to that effect and an admission note in the chart by the practitioner who admitted the patient.

(l) Properly executed informed consent, advance directive, and organ donation forms, when applicable, must be in the patient's chart before surgery, except in emergencies.

(m) The following equipment must be available to the operating room suites:

1. Call-in system;

2. Cardiac monitor;

3. Resuscitator;

4. Defibrillator;

5. Aspirator; and

6. Tracheotomy set.

(n) There must be adequate provisions for immediate pre and post-operative care.

(o) The operating room register must be complete and up-to-date.

(p) An operative report describing techniques, findings, and tissues removed or altered must be written or dictated immediately following surgery and signed by the surgeon.

(2) Anesthesia Services.

(a) If the hospital furnishes anesthesia services, they must be provided in a well organized manner under the direction of a qualified doctor of medicine or osteopathy. The service is responsible for all anesthesia administered in the hospital.

(b) The organization of anesthesia services must be appropriate to the scope of the services offered. Anesthesia must be administered only by:

1. A qualified anesthesiologist;

(Rule 1200-08-01-.07, continued)

2. A doctor of medicine or osteopathy (other than an anesthesiologist);

3. A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;

4. A certified registered nurse anesthetist (CRNA); or

5. A graduate registered nurse anesthetist under the supervision of an anesthesiologist who is immediately available if needed.

(c) Anesthesia services must be consistent with needs and resources. Policies on anesthesia procedures must include the delineation of pre-anesthesia and post-anesthesia responsibilities. The policies must ensure that the following are provided for each patient:

1. A pre-anesthesia evaluation or evaluation update conducted within forty-eight (48) hours prior to surgery by an individual qualified to administer anesthesia;

2. An intraoperative anesthesia record;

3. For each inpatient, a written post-anesthesia follow-up report prepared within forty-eight (48) hours following surgery by an individual qualified to administer anesthesia or by the person who administered the anesthesia and submits the report by telephone; and

4. For each outpatient, a post-anesthesia evaluation of anesthesia recovery prepared in accordance with policies and procedures approved by the medical staff.

(3) Nuclear Medicine Services.

(a) If the hospital provides nuclear medicine services, those services must meet the needs of the patients in accordance with acceptable standards of practice.

(b) The organization of the nuclear medicine service must be appropriate to the scope and complexity of the services offered.

(c) There must be a director who is a doctor of medicine or osteopathy qualified in nuclear medicine.

(d) The qualifications, training, functions, and responsibilities of nuclear medicine personnel must be specified by the service director and approved by the medical staff.

(e) Radioactive materials must be prepared, labeled, used, transported, stored, and disposed of in accordance with acceptable standards of practice.

(f) In-house preparation of radiopharmaceuticals is by, or under, the direct supervision of an appropriately trained registered pharmacist or a doctor of medicine or osteopathy.

(g) If laboratory tests are performed in the nuclear medicine service, the service must meet the applicable requirements for laboratory services as specified in TCA § 68-29-101, et seq.

(Rule 1200-08-01-.07, continued)

(h) Equipment and supplies must be appropriate for the types of nuclear medicine services offered and must be maintained for safe and efficient performance. The equipment must be:

1. Maintained in safe operating condition; and,

2. Inspected, tested, and calibrated at least annually by qualified personnel.

(i) The hospital must maintain signed and dated reports of nuclear medicine interpretations, consultations, and procedures. Copies of nuclear medicine reports must be maintained for at least ten (10) years.

(j) The practitioner approved by the medical staff to interpret diagnostic procedures must sign and date the interpretation of these tests.

(k) The hospital must maintain records of the receipt and disposition of radiopharmaceuticals.

(l) Nuclear medicine services must be ordered only by a practitioner whose scope of federal or state licensure and whose defined staff privileges allow such referrals.

(m) Patients are not left unattended in pre and post procedure areas.

(4) Outpatient Services.

(a) If the hospital provides outpatient services, the services must meet the needs of the patients in accordance with acceptable standards of practice.

(b) Outpatient services must be appropriately organized and integrated with inpatient services.

(c) The hospital must have appropriate professional and non-professional personnel available to provide outpatient services.

(d) Patient's rights, including a phone number to call regarding questions or concerns, shall be made readily available to outpatients.

(e) Outpatient laboratory testing in Tennessee hospitals may be ordered by the following:

1. Any licensed Tennessee practitioner who is authorized to do so by T.C.A. § 68-29-121;

2. Any out of state practitioner who has a Tennessee telemedicine license issued pursuant to rule 0880-02-.16; or

3. Any duly licensed out of state health care professional as listed in T.C.A. § 68-29-121 who is authorized by his or her state board to order outpatient laboratory testing in hospitals for individuals with whom that practitioner has an existing face-to-face patient relationship as outlined in rule 0880-02-.14(7)(a)1., 2., and 3.

(f) Outpatient diagnostic testing in Tennessee hospitals may be ordered by the following:

1. Any Tennessee practitioner licensed under Title 63 who is authorized to do so by his or her practice act;

(Rule 1200-08-01-.07, continued)

2. Any out of state practitioner who has a Tennessee telemedicine license issued pursuant to rule 0880-02-.16; or

3. Any duly licensed out of state health care professional who is authorized by his or her state board to order outpatient diagnostic testing in hospitals for individuals with whom that practitioner has an existing face-to-face patient relationship as outlined in rule 0880-02-.14(7)(a)1., 2., and 3.

(5) Emergency Services.

(a) Hospitals that elect to provide surgical services, other than in a separately licensed Ambulatory Surgical Treatment Center, must maintain and operate an emergency room.

(b) If emergency services are provided, the hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. Each hospital must have a policy which assures that all patients who present to the emergency department, are screened/triaged to determine if a medical emergency exists and stabilized when a medical emergency does exist. A hospital may deny access to patients when it is on diversionary status only because it does not have the staff or facilities in the emergency department to accept any additional emergency patients at that time. If an ambulance disregards the hospital's instructions and brings an individual on to the hospital grounds, the individual has arrived on hospital property and cannot be denied access to hospital services. Hospital property, for the purpose of this subparagraph, is considered to be:

1. The hospital's physical geographic boundaries; or

2. Ambulances owned and operated by the hospital, whenever in operation, whether or not on hospital grounds.

(c) A hospital may not delay provision of an appropriate medical screening examination in order to inquire about the individual's method of payment or insurance status.

(d) If emergency services are provided at the hospital:

1. The services must be organized under the direction of a qualified member of the medical staff;

2. The services must be integrated with other departments of the hospital; and

3. The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff. These policies and procedures must define how the hospital will assess, stabilize, treat and/or transfer patients.

(e) There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility.

(f) There shall be a sufficient number of emergency rooms and adequate equipment and supplies to accommodate the caseload of the emergency services.

(g) The entrance to the emergency department shall be clearly marked.

(h) Legend drugs in emergency rooms shall be stored in locked cabinets, except as otherwise provided for emergency drugs by the written policies and procedures of the

(Rule 1200-08-01-.07, continued)

hospital. Discharge medications may be dispensed to out-patients upon written physician orders provided that they have been packaged in containers by the pharmacist in amounts not to exceed twelve (12) hours dosage and labeled in accordance with Pharmacy Board rules.

(i) Emergency Room medical records shall include the following:

1. Identification data;

2. Information concerning the time of arrival, means and by whom transported;

3. Pertinent history of the injury or illness to include chief complaint and onset of injuries or illness;

4. Significant physical findings;

5. Description of laboratory, x-ray and EKG findings;

6. Treatment rendered;

7. Condition of the patient on discharge or transfer;

8. Diagnosis on discharge;

9. Instructions given to the patient or his family; and

10. A control register listing chronologically the patient visits to the emergency room. The record shall contain at least the patient's name, date and time of arrival and record number. The name of those dead on arrival shall be entered in the register.

(j) Emergency patients and their families are made aware of their rights, including a number to call regarding concerns or questions.

(6) Rehabilitation Services.

(a) If the hospital provides rehabilitation, physical therapy, occupational therapy, audiology, or speech pathology services, the services must be organized and staffed to ensure the health and safety of patients. These disciplines should document their contribution to the plan for patient care.

(b) The organization of the service must be appropriate to the scope of the services offered.

(c) The director of the service must have the necessary knowledge, experience, and capabilities to properly supervise and administer the services.

(d) Physical therapy, occupational therapy, speech therapy, or audiology services, if provided, must be provided by staff who meet the qualifications specified by hospital policy, consistent with state law.

~~(e) Services must be furnished in accordance with a written plan of treatment. Services must be given in accordance with orders of practitioners who are authorized by the medical staff to order the services and the orders must be incorporated in the patient's record.~~

(Rule 1200-08-01-.07, continued)

(e) Services must be furnished in accordance with a written plan of treatment in accordance with the practice acts of the practitioners who are authorized by medical staff to provide the services. The written plan of treatment must be incorporated in the patient's record.

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(7) Obstetrical Services.

(a) If a hospital provides obstetrical services it shall have space, facilities, equipment and qualified personnel to assure appropriate treatment of all maternity patients and newborns.

(b) The hospital must have written policies and procedures governing medical care provided in the obstetrical service which are established by and are a continuing responsibility of the medical staff.

(c) Provisions must be made for care of the patient during labor and delivery, either in the patient's room or in a designated room.

(d) Designated delivery rooms shall be segregated from patient areas and be located so as not to be used as a passageway between or subject to contamination from other parts of the hospital.

(e) A delivery record shall be kept that must indicate:

1. The name of the patient;
2. Her maiden name;
3. Date of delivery;
4. Sex of infant;
5. Name of physician;
6. Names of persons assisting;
7. What complications, if any, occurred;
8. Type of anesthesia used;
9. Name of person administering anesthesia; and
10. Other persons present.

(8) Pediatric Services.

(a) If the hospital provides pediatric services, it shall provide appropriate pediatric equipment and supplies.

(b) Pediatric services must be appropriate to the scope and complexity of the services offered and must meet the needs of the patients in accordance with acceptable standards of practice.

(Rule 1200-08-01-.07, continued)

(c) The hospital must have appropriate professional and non-professional personnel available to provide pediatric services.

(9) Respiratory Care Services.

(a) If the hospital provides respiratory care services, the hospital must meet the needs of the patients in accordance with acceptable standards of practice.

(b) The organization of the respiratory care services must be appropriate to the scope and complexity of the services offered.

(c) There must be a director of respiratory care services who is a doctor of medicine or osteopathy with the knowledge, experience, and capabilities to supervise and administer the service properly.

(d) There must be adequate numbers of certified respiratory therapists, certified respiratory therapy technicians, and other personnel who meet the qualifications specified by the medical staff, consistent with state law.

(e) Services must be delivered in accordance with medical staff directives.

(f) Personnel qualified to perform specific procedures and the amount of supervision required for personnel to carry out specific procedures must be designated in writing.

(g) If blood gases or other laboratory tests are performed in the respiratory care unit, the unit must meet the applicable requirements for clinical laboratory services specified in the Tennessee Medical Laboratory Act.

(10) Social Work Services.

(a) If the hospital provides social work services, the services must be available to the patient, the patient's family and other persons significant to the patient, in order to facilitate adjustment of these individuals to the impact of illness and to promote maximum benefits from the health care services provided.

(b) Social work services shall include psychosocial assessment, counseling, coordination of discharge planning, community liaison services, financial assistance and consultation.

(c) Social work services shall be provided by personnel who satisfy applicable accreditation standards and who are in compliance with Tennessee State Law governing social work practices. Social work personnel employed by the hospital prior to the effective date of these regulations shall be deemed to meet this requirement.

(d) Facilities for social work services shall be readily accessible and shall permit privacy for interviews and counseling.

(11) Psychiatric Services.

(a) If a hospital provides psychiatric services, a psychiatric unit devoted exclusively for the care and treatment of psychiatric patients and professional personnel qualified in the diagnosis and treatment of patients with psychiatric illnesses shall be provided. Adequate protection shall be provided for patients and the staff against any physical injury resulting from a patient becoming violent. A psychiatric unit shall meet the requirements as needed to care for patients admitted, either through direct care or by contractual arrangements.

(Rule 1200-08-01-.07, continued)

(b) A hospital licensed by the Department of Health as a satellite hospital whose primary purpose is the provision of mental health or mental retardation services, must verify to the Department that Standards of the Department of Mental Health and Mental Retardation are satisfied.

(12) Alcohol and Drug Services.

(a) If a hospital provides alcohol and drug services, the service shall be devoted exclusively to the care and treatment of alcohol and drug dependent patients and have on staff physicians and other professional personnel qualified in the diagnosis and treatment of alcoholism and drug addiction.

(b) Adequate protection shall be provided for the patients and staff against any physical injury resulting from a patient becoming disturbed or violent. Alcohol and drug services shall meet the requirements as needed to care for patients admitted, either through direct care or by contractual arrangements.

(13) Perinatal and/or Neonatal Care Services. Any hospital providing perinatal and/or neonatal care services shall comply with the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities developed by the Tennessee Department of Health's Perinatal Advisory Committee, June 1997 including amendments as necessary.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-57-101, 68-57-102, 68-57-104, and 68-57-105.* ***Administrative History:*** *Original rule filed March 18, 2000; effective May 30, 2000. Amendment filed April 17, 2000; effective July 1, 2000. Amendment filed June 12, 2003; effective August 26, 2003. Amendment filed July 27, 2005; effective October 10, 2005. Amendment filed February 23, 2006; effective May 9, 2006. Amendment filed February 23, 2007; effective May 9, 2007. Amendment filed February 22, 2010; effective May 23, 2010. Amendment filed January 3, 2012; effective April 2, 2012. Amendment filed March 27, 2015; effective June 25, 2015.*

1200-08-01-.08 BUILDING STANDARDS.

(1) A hospital shall construct, arrange, and maintain the condition of the physical plant and the overall hospital environment in such a manner that the safety and well-being of the patients are assured.

(2) After the applicant has submitted an application and licensure fees, the applicant must submit the building construction plans to the department. All facilities shall conform to the current edition of the following applicable codes as approved by the Board for Licensing Health Care Facilities: International Building Code (excluding Chapters 1 and 11) including referenced International Fuel Gas Code, International Mechanical Code, and International Plumbing Code; National Fire Protection Association (NFPA) NFPA 101 Life Safety Code excluding referenced NFPA 5000; Guidelines for Design and Construction of Health Care Facilities (FGI) including referenced Codes and Standards; U.S. Public Health Service Food Code; and Americans with Disabilities Act (ADA) Standards for Accessible Design. When referring to height, area or construction type, the International Building Code shall prevail. Where there are conflicts between requirements in local codes, the above listed codes, regulations and provisions of this chapter, the most stringent requirements shall apply.

(3) The codes in effect at the time of submittal of plans and specifications, as defined by these rules, shall be the codes to be used throughout the project.

(4) A licensed contractor shall perform all new construction and renovations to hospitals, other than minor alterations not affecting fire and life safety or functional issues, in accordance with

RULES
OF
TENNESSEE DEPARTMENT OF HEALTH
BOARD FOR LICENSING HEALTH CARE FACILITIES
DIVISION OF HEALTH CARE FACILITIES

CHAPTER 1200-08-06
STANDARDS FOR NURSING HOMES

TABLE OF CONTENTS

1200-08-06-.01 DEFINITIONS.

(1) Abuse. The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.

(2) Administrator. A person currently licensed as such by the Tennessee Board of Examiners for Nursing Home Administrators.

(3) Adult. An individual who has capacity and is at least 18 years of age.

(4) Advance Directive. An individual instruction or a written statement relating to the subsequent provision of health care for the individual, including, but not limited to, a living will or a durable power of attorney for health care.

(5) Agent. An individual designated in an advance directive for health care to make a health care decision for the individual granting the power.

(6) Board. The Tennessee Board for Licensing Health Care Facilities.

(7) Capacity. An individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision. These regulations do not affect the right of a resident to make health care decisions while having the capacity to do so. A resident shall be presumed to have capacity to make a health care decision, to give or revoke an advance directive, and to designate or disqualify a surrogate. Any person who challenges the capacity of a resident shall have the burden of proving lack of capacity.

(8) Cardiopulmonary Resuscitation (CPR). The administering of any means or device to restore or support cardiopulmonary functions in a resident, whether by mechanical devices, chest compressions, mouth-to-mouth resuscitation, cardiac massage, tracheal intubation, manual or mechanical ventilations or respirations, defibrillation, the administration of drugs and/or chemical agents intended to restore cardiac and/or respiratory functions in a resident where cardiac or respiratory arrest has occurred or is believed to be imminent.

(9) Certified Nurse Aide or Certified Nursing Assistant. An individual who has successfully completed an approved nursing assistant training program and is registered with the department.

(Rule 1200-08-06-.01, continued)

(10) Clinical Fellow. A Speech Language Pathologist who is in the process of obtaining his or her paid professional experience, as defined by a Communications Disorders and Sciences Board-approved accreditation agency, before being qualified for licensure.

(11) Commissioner. The Commissioner of the Tennessee Department of Health or his or her authorized representative.

(12) Competent. A resident who has capacity.

(13) Department. The Tennessee Department of Health.

(14) Designated Physician. A physician designated by an individual or the individual's agent, guardian, or surrogate, to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes such responsibility.

(15) Dietitian. A person currently licensed as such by the Tennessee Board of Dietitian/Nutritionist Examiners. Persons exempt from licensure shall be registered with the American Dietetics Association pursuant to T.C.A. § 63-25-104.

(16) Director of Nursing (DON). A Registered Nurse employed full time in a nursing home who satisfies the responsibilities set forth in this chapter.

(17) Do-Not-Resuscitate Order (DNR). A written order, other than a POST, not to resuscitate a patient in cardiac or respiratory arrest in accordance with accepted medical practices.

(18) Emancipated Minor. Any minor who is or has been married or has by court order or otherwise been freed from the care, custody and control of the minor's parents.

(19) Emergency Responder. A paid or volunteer firefighter, law enforcement officer, or other public safety official or volunteer acting within the scope of his or her proper function under law or rendering emergency care at the scene of an emergency.

(20) Guardian. A judicially appointed guardian or conservator having authority to make a health care decision for an individual.

(21) Hazardous Waste. Materials whose handling, use, storage, and disposal are governed by local, state or federal regulations.

(22) Health Care. Any care, treatment, service or procedure to maintain, diagnose, treat, or otherwise affect an individual's physical or mental condition, and includes medical care as defined in T.C.A. § 32-11-103(5).

(23) Health Care Decision. Consent, refusal of consent or withdrawal of consent to health care.

(24) Health Care Decision-maker. In the case of a resident who lacks capacity, the resident's health care decision-maker is one of the following: the resident's health care agent as specified in an advance directive, the resident's court-appointed guardian or conservator with health care decision-making authority, the resident's surrogate as determined pursuant to Rule 1200-08-06-.13 or T.C.A. § 33-3-220, the designated physician pursuant to these Rules or in the case of a minor child, the person having custody or legal guardianship.

(25) Health Care Institution. A health care institution as defined in T.C.A. § 68-11-1602.

(Rule 1200-08-06-.01, continued)

(26) Health Care Provider. A person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care in the ordinary course of business or practice of a profession.

(27) Hospital. Any institution, place, building or agency represented and held out to the general public as ready, willing and able to furnish care, accommodations, facilities and equipment for the use, in connection with the services of a physician or dentist, of one (1) or more nonrelated persons who may be suffering from deformity, injury or disease or from any other condition for which nursing, medical or surgical services would be appropriate for care, diagnosis or treatment.

(28) Hospitalization. The reception and care of any person for a continuous period longer than twenty-four (24) hours, for the purpose of giving advice, diagnosis, nursing service or treatment bearing on the physical health of such person, and maternity care involving labor and delivery for any period of time.

(29) Incompetent. A resident who has been adjudicated incompetent by a court of competent jurisdiction and has not been restored to legal capacity.

(30) Individual instruction. An individual's direction concerning a health care decision for the individual.

(31) Infectious Waste. Solid or liquid wastes which contain pathogens with sufficient virulence and quantity such that exposure to the waste by a susceptible host could result in an infectious disease.

(32) Involuntary Transfer. The movement of a resident between nursing homes, without the consent of the resident, the resident's legal guardian, next of kin or representative.

(33) Licensed Practical Nurse. A person currently licensed as such by the Tennessee Board of Nursing.

(34) Licensee. The person or entity to whom the license is issued. The licensee is held responsible for compliance with all rules and regulations.

(35) Life Threatening Or Serious Injury. Injury requiring the patient to undergo significant additional diagnostic or treatment measures.

(36) Medical Director. A licensed physician employed by the nursing home to be responsible for medical care in the facility.

(37) Medical Emergency. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the resident's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

(38) Medical Equipment. Equipment used for the diagnosis, treatment and monitoring of patients, including, but not limited to, oxygen care equipment and oxygen delivery systems, enteral and parenteral feeding pumps, and intravenous pumps.

(39) Medical Record. Medical histories, records, reports, summaries, diagnoses, prognoses, records of treatment and medication ordered and given, entries, x-rays, radiology interpretations and other written, electronic, or graphic data prepared, kept, made or maintained in a facility that pertains to confinement or services rendered to residents.

(Rule 1200-08-06-.01, continued)

(40) Medically Inappropriate Treatment. Resuscitation efforts that cannot be expected either to restore cardiac or respiratory function to the resident or other medical or surgical treatments to achieve the expressed goals of the informed resident. In the case of the incompetent resident, the resident's representative expresses the goals of the resident.

(41) Misappropriation of Patient/Resident Property. The deliberate misplacement, exploitation or wrongful, temporary or permanent use of an individual's belongings or money without the individual's consent.

(42) Neglect. The failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness; however, the withholding of authorization for or provision of medical care to any terminally ill person who has executed an irrevocable living will in accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of the living will, shall not be deemed "neglect" for purposes of these rules.

(43) NFPA. The National Fire Protection Association.

(44) Nurse Aide or Nursing Assistant Training Program. A specialized program approved by the Department to provide classroom instruction and supervised clinical experience for individuals who wish to be employed as Nurse Aides or Nursing Assistants.

(45) Nursing Personnel. Licensed nurses and certified nurse aides who provide nursing care.

(46) Occupational Therapist. A person currently licensed as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

~~(47) Patient Abuse. Patient neglect, intentional infliction of pain, injury, or mental anguish. Patient abuse includes the deprivation of services by a caretaker which are necessary to maintain the health and welfare of a patient or resident; however, the withholding of authorization for or provision of medical care to any terminally ill person who has executed an irrevocable living will in accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of such living will shall not be deemed "patient abuse" for purposes of these rules.~~

(47)~~(48)~~ Person. An individual, corporation, estate, trust, partnership, association, joint venture, government, governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

(48)~~(49)~~ Personally Informing. A communication by any effective means from the resident directly to a health care provider.

(49)~~(50)~~ Pharmacist. A person currently licensed as such by the Tennessee Board of Pharmacy.

(50)~~(51)~~ Physical Therapist. A person currently licensed as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(51)~~(52)~~ Physician Assistant. A person who has graduated from a physician assistant educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant, has passed the Physician Assistant National Certifying Examination, and is currently licensed in Tennessee as a physician assistant under title 63, chapter 19.

(52)~~(53)~~ Physician Orders for Scope of Treatment or POST. Written orders that:

(a) Are on a form approved by the Board for Licensing Health Care Facilities;

(Rule 1200-08-06-.01, continued)

(b) Apply regardless of the treatment setting and that are signed as required herein by the patient's physician, physician assistant, nurse practitioner, or clinical nurse specialist; and

(c)

1. Specify whether, in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should or should not be attempted;

2. Specify other medical interventions that are to be provided or withheld; or

3. Specify both 1 and 2.

(53)~~(54)~~ Physician. An individual authorized to practice medicine or osteopathy under Tennessee Code Annotated, Title 63, Chapters 6 or 9.

(54)~~(55)~~ Podiatrist. A person currently licensed as such by the Tennessee Board of Registration in Podiatry.

(55)~~(56)~~ Power of Attorney for Health Care. The designation of an agent to make health care decisions for the individual granting the power under T.C.A. Title 34, Chapter 6, Part 2.

(56)~~(57)~~ Program Coordinator. A registered nurse who possesses a minimum of two years nursing experience with at least one year in long term care and is responsible for ensuring that the requirements of the Nurse Aide Training Program are met.

(57)~~(58)~~ Qualified Emergency Medical Service Personnel. Includes, but shall not be limited to, emergency medical technicians, paramedics, or other emergency services personnel, providers, or entities acting within the usual course of their professions, and other emergency responders.

(58)~~(59)~~ Reasonably Available. Readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the resident's health care needs. Such availability shall include, but not be limited to, availability by telephone.

(59)~~(60)~~ Registered Nurse. A person currently licensed as such by the Tennessee Board of Nursing.

(60)~~(61)~~ Resident/Patient. Includes but is not limited to any person who is suffering from an illness or injury and who is in need of nursing care.

(61)~~(62)~~ Secured Unit. A facility or distinct part of a facility where residents are intentionally denied egress by any means.

(62)~~(63)~~ Shall or Must. Compliance is mandatory.

(63)~~(64)~~ Social Worker. In a facility with more than 120 beds a qualified social worker is an individual with:

(a) A bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and,

(b) One year of supervised social work experience in a health care setting working directly with individuals.

(Rule 1200-08-06-.01, continued)

(64)~~(65)~~ Speech Language Pathologist. As defined in T.C.A. § 63-17-103, a person currently licensed as such by the Tennessee Board of Communications Disorders and Sciences.

(65)~~(66)~~ State. A state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.

(66)~~(67)~~ Student. A person currently enrolled in a course of study that is approved by the appropriate licensing board.

(67)~~(68)~~ Supervising Health Care Provider. The designated physician or, if there is no designated physician or the designated physician is not reasonably available, the health care provider who has undertaken primary responsibility for an individual's health care.

(68)~~(69)~~ Surrogate. An individual, other than a resident's agent or guardian, authorized to make a health care decision for the resident.

(69)~~(70)~~ Survey. An on-site examination by the department to determine the quality of care and/or services provided.

(70)~~(71)~~ Transfer. The movement of a resident between nursing homes at the direction of a physician or other qualified medical personnel when a physician is not readily available. The term does not include movement of a resident who leaves the facility against medical advice. The term does not apply to the commitment and movement of mentally ill and mentally retarded persons, the discharge or release of a resident no longer in need of nursing home care, or a nursing home's refusal, after an appropriate medical screening, to render any medical care on the grounds that the person does not have a medical need for nursing home care.

(71)~~(72)~~ Treating Health Care Provider. A health care provider who at the time is directly or indirectly involved in providing health care to the resident.

(72)~~(73)~~ Treating Physician. The physician selected by or assigned to the resident and who has the primary responsibility for the treatment and care of the resident. Where more than one physician shares such responsibility, any such physician may be deemed to be the "treating physician."

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 39-11-106, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-224, 68-11-234, 68-11-1802, and 71-6-121.* ***Administrative History:*** *Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed April 10, 2000; effective June 24, 2000. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed April 28, 2003; effective July 12, 2003. Amendments filed September 21, 2005; effective December 5, 2005. Amendment filed February 7, 2007; effective April 23, 2007. Amendment filed July 18, 2007; effective October 1, 2007. Amendment filed January 3, 2012; effective April 2, 2012. Amendment filed March 27, 2015; effective June 25, 2015. Amendment filed September 15, 2015; effective December 14, 2015.*

1200-08-06-.02 LICENSING PROCEDURES.

(1) No person, partnership, association, corporation, or state, county or local government unit, or any division, department, board or agency thereof, shall establish, conduct, operate, or maintain in the State of Tennessee any nursing home without having a license. A license shall be issued only to the applicant named and only for the premises listed in the application for licensure. Satellite facilities shall be prohibited. Licenses are not transferable or

(Rule 1200-08-10-.03, continued)

(4) Either failure to submit a plan of correction in a timely manner or a finding by the department that the plan of correction is unacceptable shall subject the ambulatory surgical treatment center's license to possible disciplinary action.

(5) Any licensee or applicant for a license, aggrieved by a decision or action of the department or board, pursuant to this chapter, may request a hearing before the board. The proceedings and judicial review of the board's decision shall be in accordance with the Uniform Procedures Act, T.C.A. § 4-5-101 et seq.

(6) Reconsideration and Stays. The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-04-01-.18 regarding petitions for reconsiderations and stays in that case.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 4-5-219, 4-5-312, 4-5-316, 4-5-317, 68-11-202, 68-11-204, 68-11-206, 68-11-208, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed July 22, 1977; effective August 22, 1977. Repeal and new rule filed June 30, 1992; effective August 14, 1992. Repeal and new rule filed March 21, 2000; effective June 4, 2000. Amendment filed March 1, 2007; effective May 15, 2007.*

1200-08-10-.04 ADMINISTRATION.

(1) The ASTC must have an effective governing body legally responsible for the conduct of the ASTC. If an ASTC does not have an organized governing body, the persons legally responsible for the conduct of the ASTC must carry out the functions specified in this chapter.

(2) The governing body shall appoint a chief executive officer or administrator who is responsible for managing the ASTC. The chief executive officer or administrator shall designate an individual to act for him or her in his or her absence, in order to provide the ASTC with administrative direction at all times.

(3) The governing body, whether it be that of the center alone or that of a parent organization, shall establish effective mechanisms to ensure the accountability of the center's medical staff and other professional personnel.

(4) The governing body shall assure that the ASTC has the financial resources to provide the services essential to the operation of the facility.

(5) Staffing shall be adequate to provide the services essential to the operation of the ASTC.

(6) The ambulatory surgical treatment center shall ensure a framework for addressing issues related to care at the end of life.

(7) The ambulatory surgical treatment center shall provide a process that assesses pain in all patients. There shall be an appropriate and effective pain management program.

(8) The ASTC shall perform only those surgical procedures which can be safely and effectively carried out on an outpatient basis.

(9) Each ASTC shall have at all times a designated Medical Director who shall be a licensed physician or dentist who shall be responsible for the direction and coordination of medical programs.

(10) Staff education programs and training sessions shall include life safety, medical equipment, utility systems, infection control and hazardous waste practices. At least two (2) on duty members of the facility shall be trained in emergency resuscitation.

(Rule 1200-08-10-.04, continued)

(11) When licensure is applicable for a particular job, a copy of the current license must be included as a part of the personnel file. Each personnel file shall contain accurate information as to the education, training, experience and personnel background of the employee. Adequate medical screenings to exclude communicable disease shall be required of each employee.

(12) Whenever the rules and regulations of this chapter require that a licensee develop a written policy, plan, procedure, technique, or system concerning a subject, the licensee shall develop the required policy, maintain it and adhere to its provisions. An ASTC which violates a required policy also violates the rule and regulation establishing the requirement.

(13) Policies and procedures shall be consistent with professionally recognized standards of practice.

(14) No ASTC shall retaliate against or, in any manner, discriminate against any person because of a complaint made in good faith and without malice to the board, the department, the Adult Protective Services, or the Comptroller of the State Treasury. An ASTC shall neither retaliate, nor discriminate, because of information lawfully provided to these authorities, because of a person's cooperation with them, or because a person is subpoenaed to testify at a hearing involving one of these authorities.

(15) When services such as dietary, laundry or therapy services are purchased from others, the governing body shall be responsible to assure the supplier(s) meet the same local and state standards the facility would have to meet if it were providing those services itself using its own staff.

(16) The governing body shall provide for the appointment, reappointment or dismissal of members of the medical, dental, and other health professions and provide for the granting of clinical privileges.

(17) The governing body shall ensure that there is a written facility agreement with one or more acute care general hospitals licensed by the state, which will admit any patient referral who requires continuing care.

(18) Each ASTC shall specify the classification of services to be provided in the facility and list authorized surgical procedures.

(19) Where the physician-owner-operator serves as the governing body, the articles of incorporation or other written organizational plan shall describe the manner in which the owner-operator executes the governing body responsibility.

(20) Infection Control.

(a) The ASTC must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active performance improvement program for the prevention, control, and investigation of infections and communicable diseases.

(b) The physical environment of the ambulatory surgical treatment center shall be maintained in a safe, clean and sanitary manner.

1. Any condition on the ambulatory surgical treatment center site conducive to the harboring or breeding of insects, rodents or other vermin shall be prohibited. Chemical substances of a poisonous nature used to control or eliminate vermin

(Rule 1200-08-10-.04, continued)

shall be properly identified. Such substances shall not be stored with or near food or medications.

2. Cats, dogs or other animals shall not be allowed in any part of the ambulatory surgical treatment center except for specially trained animals for the handicapped and except as addressed by ambulatory surgical treatment center policy for pet therapy programs. The ambulatory surgical treatment center shall designate in its policies and procedures those areas where animals will be excluded. The areas designated shall be determined based upon an assessment of the ambulatory surgical treatment center performed by medically trained personnel.

~~3. A bed complete with mattress and pillow shall be provided. In addition, patient units shall be provided with at least one chair, a bedside table, an over bed tray and adequate storage space for toilet articles, clothing and personal belongings.~~

3. The layout of patient care areas of the ASTC, as well as the personal items offered to the patient, shall be outlined in the ASTC's policy and be based on the type of procedure performed on the patient.

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4. Individual wash cloths, towels and bed linens must be provided for each patient. Linen shall not be interchanged from patient to patient until it has been properly laundered.

5. Bath basin water service, emesis basin, bedpan and urinal shall be individually provided.

6. Water pitchers, glasses, thermometers, emesis basins, douche apparatus, enema apparatus, urinals, mouthwash cups, bedpans and similar items of equipment coming into intimate contact with patients shall be disinfected or sterilized after each use unless individual equipment for each is provided and then sterilized or disinfected between patients and as often as necessary to maintain them in a clean and sanitary condition. Single use, patient disposable items are acceptable but shall not be reused.

(c) The chief executive officer or administrator shall assure that an infection control committee including members of the medical staff, nursing staff and administrative staff develops guidelines and techniques for the prevention, surveillance, control and reporting of facility infections. Duties of the committee shall include the establishment of:

1. Written infection control policies;

2. Techniques and systems for identifying, reporting, investigating and controlling infections in the facility;

3. Written procedures governing the use of aseptic techniques and procedures in all areas of the facility, including adoption of a standardized central venous catheter insertion process which shall contain these key components:

(i) Hand hygiene (as defined in 1200-08-10-.04(20)(g));

(Rule 1200-08-10-.04, continued)

(ii) Maximal barrier precautions to include the use of sterile gowns, gloves, mask and hat, and large drape on patient;

(iii) Chlorhexidine skin antisepsis;

(iv) Optimal site selection;

(v) Daily review of line necessity; and

(vi) Development and utilization of a procedure checklist;

4. Written procedures concerning food handling, laundry practices, disposal of environmental and patient wastes, traffic control and visiting rules in high risk areas, sources of air pollution, and routine culturing of autoclaves and sterilizers;

5. A log of incidents related to infectious and communicable diseases;

6. A method of control used in relation to the sterilization of supplies and water, and a written policy addressing reprocessing of sterile supplies;

7. Formal provisions to educate and orient all appropriate personnel in the practice of aseptic techniques such as handwashing and scrubbing practices, proper grooming, masking and dressing care techniques, disinfecting and sterilizing techniques, and the handling and storage of patient care equipment and supplies; and,

8. Continuing education provided for all facility personnel on the cause, effect, transmission, prevention, and elimination of infections, as evidenced by front line employees verbalizing understanding of basic techniques.

(d) The chief executive officer, the medical staff and the chief nursing officer must ensure that the facility-wide performance improvement program and training programs address problems identified by the infection control committee and must be responsible for the implementation of successful corrective action plans in affected problem areas.

(e) The facility shall develop policies and procedures for testing a patient's blood for the presence of the hepatitis B virus and the HIV (AIDS) virus in the event that an employee of the facility, a student studying at the facility, or other health care provider rendering services at the facility is exposed to a patient's blood or other body fluid. The testing shall be performed at no charge to the patient, and the test results shall be confidential.

(f) The facility shall have an annual influenza vaccination program which shall include at least:

1. The offer of influenza vaccination to all staff and independent practitioners or accept documented evidence of vaccination from another vaccine source or facility;

2. A signed declination statement on record from all who refuse the influenza vaccination for other than medical contraindications;

3. Education of all direct care personnel about the following:

(i) Flu vaccination,

(ii) Non-vaccine control measures, and

(iii) The diagnosis, transmission, and potential impact of influenza;

4. An annual evaluation of the influenza vaccination program and reasons for non-participation; and

5. The requirements to complete vaccinations or declination statements are suspended by the Medical Director in the event of a vaccine shortage.

(g) The facility and its employees shall adopt and utilize standard precautions (per CDC) for preventing transmission of infections, HIV, and communicable diseases, including adherence to a hand hygiene program which shall include:

1. Use of alcohol-based hand rubs or use of non-antimicrobial or antimicrobial soap and water before and after each patient contact if hands are not visibly soiled;

2. Use of gloves during each patient contact with blood or where other potentially infectious materials, mucous membranes, and non-intact skin could occur and gloves changed before and after each patient contact;

3. Use of either a non-antimicrobial soap and water or an antimicrobial soap and water for visibly soiled hands; and

4. Health care worker education programs which may include:

(i) Types of patient care activities that can result in hand contamination;

(ii) Advantages and disadvantages of various methods used to clean hands;

(iii) Potential risks of health care workers' colonization or infection caused by organisms acquired from patients; and

(iv) Morbidity, mortality, and costs associated with health care associated infections.

(h) All ASTC's shall adopt appropriate policies regarding the testing of patients and staff for human immunodeficiency virus (HIV) and any other identified causative agent of acquired immune deficiency syndrome.

(21) Performance Improvement. The ASTC shall have a planned, systematic, organization-wide approach to process design and redesign, performance measurement, assessment and improvement which is approved by the designated medical staff committee of the facility, the owner and/or the governing body. This plan shall address and/or include, but is not limited to:

(a) Infection control, including post-operative surveillance;

(b) Complications arising after the patient was admitted;

(c) Documentation of periodic review of the data collected and follow-up actions;

(d) A system which identifies appropriate plans of action to correct identified quality deficiencies;

(Rule 1200-08-10-.04, continued)

(e) Documentation that the above policies are being followed and that appropriate action is taken whenever indicated.

(f) The facility shall develop and implement a system for measuring improvements in adherence to the hand hygiene program, central venous catheter insertion process, and influenza vaccination program.

(22) The ASTC shall ensure a framework for addressing issues related to care at the end of life.

(23) The ASTC shall provide a process that assesses pain in all patients. There shall be an appropriate and effective pain management program.

(24) All health care facilities licensed pursuant to T.C.A. §§ 68-11-201, et seq. shall post the following in the main public entrance:

(a) Contact information including statewide toll-free number of the division of adult protective services, and the number for the local district attorney's office;

(b) A statement that a person of advanced age who may be the victim of abuse, neglect, or exploitation may seek assistance or file a complaint with the division concerning abuse, neglect and exploitation; and

(c) A statement that any person, regardless of age, who may be the victim of domestic violence may call the nationwide domestic violence hotline, with that number printed in boldface type, for immediate assistance and posted on a sign no smaller than eight and one-half inches (8½") in width and eleven inches (11") in height.

Postings of (a) and (b) shall be on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height.

(25) "No smoking" signs or the international "No Smoking" symbol, consisting of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it, shall be clearly and conspicuously posted at every entrance.

(26) The facility shall develop a concise statement of its charity care policies and shall post such statement in a place accessible to the public.

(27) Informed Consent

(a) Any ambulatory surgical treatment center in which abortions, other than abortions necessary to prevent the death of the pregnant female, are performed shall conspicuously post a sign in a location defined below so as to be clearly visible to patients, which reads:

Notice: It is against the law for anyone, regardless of the person's relationship to you, to coerce you into having or to force you to have an abortion. By law, we cannot perform an abortion on you unless we have your freely given and voluntary consent. It is against the law to perform an abortion on you against your will. You have the right to contact any local or state law enforcement agency to receive protection from any actual or threatened criminal offense to coerce an abortion.

(b) The sign shall be printed in languages appropriate for the majority of clients of the facility with lettering that is legible and that is Arial font, at least 40-point bold-faced type.

(Rule 1200-08-10-.04, continued)

(c) A facility in which abortions are performed that is an ambulatory surgical treatment center shall post the required sign in each patient waiting room and patient consultation room used by patients on whom abortions are performed.

(d) An ambulatory surgical treatment center shall be assessed a civil penalty by the board for licensing health care facilities of two thousand five hundred dollars ($2,500.00) for each day of violation in which:

1. The sign required above was not posted during business hours when patients or prospective patients are present; and

2. An abortion other than an abortion necessary to prevent the death of the pregnant female was performed in the ambulatory surgical treatment center.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 39-15-202, 39-17-1803, 39-17-1805, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-216, 68-11-268 and 71-6-121.* ***Administrative History:*** *Original rule filed July 22, 1977; effective August 22, 1977. Amendment filed September10, 1991; effective October 25, 1991. Repeal and new rule filed June 30, 1992; effective August 14, 1992. Repeal and new rule filed March 21, 2000; effective June 4, 2000. Amendment filed June 18, 2002; effective September 1, 2002. Amendment filed June 16, 2003; effective August 30, 2003. Amendment filed September 9, 2005; effective November 23, 2005. Amendment filed April 20, 2006; effective July 4, 2006. Amendment filed July 18, 2007; effective October 1, 2007. Amendment filed October 11, 2007; effective December 25, 2007. Amendment filed February 22, 2010; effective May 23, 2010. Amendment filed December 16, 2013; effective March 16, 2014.*

1200-08-10-.05 ADMISSIONS, DISCHARGES, AND TRANSFERS.

(1) Every person admitted for care or treatment to any ASTC shall be under the supervision of a physician licensed to practice in Tennessee. The name, address and telephone number of the physician attending the patient shall be recorded in the patient's medical record.

(2) The above does not preclude the admission of a patient to an ASTC by a dentist or podiatrist licensed to practice in Tennessee with the concurrence of a physician member of the medical staff.

(3) This does not preclude qualified oral and maxillo-facial surgeons from admitting patients and completing the admission history and physical examination and assessing the medical risk of the procedure on their patients. A physician member of the medical staff is responsible for the management of medical problems.

(4) The facility shall ensure that no person on the grounds of race, color, national origin, or handicap, will be excluded from participation in, be denied benefits of, or otherwise subjected to discrimination in the provision of any care or service of the facility. The facility shall protect the civil rights of residents under the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

(5) For purposes of this chapter, the requirements for signature or countersignature by a physician, dentist, podiatrist or other person responsible for signing, countersigning or authenticating an entry may be satisfied by the electronic entry by such person of a unique code assigned exclusively to him or her, or by entry of other unique electronic or mechanical symbols, provided that such person has adopted same as his or her signature in accordance with established ASTC protocol or rules.

(6) Each ASTC must have a written transfer agreement with a local hospital.

(Rule 1200-08-10-.10, continued)

(10) Human anatomical remains which are transferred to a mortician for cremation or burial shall be exempt from the requirements of this subparagraph. Any other human limbs and recognizable organs must be incinerated or discharged (following grinding) to the sewer.

(11) All garbage, trash and other non-infectious wastes shall be stored and disposed of in a manner that must not permit the transmission of disease, create a nuisance, provide a breeding place for insects and rodents, or constitute a safety hazard. All containers for waste shall be water tight, be constructed of easily cleanable material and be kept on elevated platforms.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed July 22, 1977; effective August 22, 1977. Amendment filed July 3, 1984; effective August 1, 1984. Repeal and new rule filed June 30, 1992; effective August 14, 1992. Repeal and new rule filed March 21, 2000; effective June 4, 2000. Amendment filed June 16, 2003; effective August 30, 2003. Amendment filed September 9, 2005; effective November 23, 2005.*

1200-08-10-.11 RECORDS AND REPORTS.

(1) The Joint Annual Report of Ambulatory Surgical Treatment Centers shall be filed with the department. The forms are furnished and mailed to each ASTC by the department each year and the forms must be completed and returned to the department as required.

(2) The facility shall report information contained in the medical records of patients who have cancer or pre-cancerous or tumorous diseases as provided by existing regulations. These reports shall be sent to the Cancer Reporting System of the department on a quarterly schedule no later than six (6) months after the date of the diagnosis or treatment.

~~(3) The ASTC shall report to the department each case of communicable disease detected in the center. Repeated failure to report communicable diseases shall be cause for revocation of an ASTC's license.~~

(3) The ASTC shall report to the department each patient case of communicable disease detected in the center. Repeated failure to report communicable diseases shall be cause for revocation of an ASTC's license. The ASTC shall monitor outbreaks of communicable diseases in the nearby geographical area of the facility and inform the ASTC staff of these outbreaks in order for the employees to contact their personal physician for consultation regarding their vaccination status.

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(4) The ASTC shall report all incidents of abuse, neglect, and misappropriation to the Department of Health in accordance with T.C.A. § 68-11-211.

(5) The ASTC shall report the following incidents to the Department of Health in accordance with T.C.A. § 68-11-211.

(a) Strike by staff at the facility;

(b) External disasters impacting the facility;

(c) Disruption of any service vital to the continued safe operation of the ASTC or to the health and safety of its patients and personnel; and

(d) Fires at the ASTC that disrupt the provision of patient care services or cause harm to the patients or staff, or that are reported by the facility to any entity, including but not limited to a fire department charged with preventing fires.

(Rule 1200-08-10-.11, continued)

(6) The ASTC shall retain legible copies of the following records and reports which shall be retained in the facility, shall be maintained in a single file, and shall be made available for inspection during normal business hours to any patient who requests to view them for thirty-six (36) months following their issuance:

(a) Local fire safety inspections;

(b) Local building code inspections, if any;

(c) Fire marshal reports;

(d) Department licensure and fire safety inspections and surveys;

(e) Department quality assurance surveys, including follow-up visits, and certification inspections, if any;

(f) Federal Health Care Financing Administration surveys and inspections, if any;

(g) Orders of the Commissioner or Board, if any;

(h) Comptroller of the Treasury's audit reports and finding, if any; and,

(i) Maintenance records of all safety equipment.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-1-1004, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, and 68-11-216.* ***Administrative History:*** *Original rule filed July 22, 1977; effective August 22, 1977. Amendment filed September 10, 1991; effective October 25, 1991. Repeal and new rule filed June 30, 1992; effective August 14, 1992. Repeal and new rule filed March 21, 2000; effective June 4, 2000. Amendment filed April 11, 2003; effective June 25, 2003. Amendments filed January 3, 2012; effective April 2, 2012.*

1200-08-10-.12 PATIENT RIGHTS.

(1) Each patient has at least the following rights:

(a) To privacy in treatment and personal care;

(b) To be free from mental and physical abuse. Should this right be violated, the facility must notify the department within five (5) business days and the Tennessee Department of Human Services, Adult Protective Services immediately as required by T.C.A. § 71-6-101 et seq;

(c) To refuse treatment. The patient must be informed of the consequences of that decision, the refusal and its reason must be reported to the physician and documented in the medical record;

(d) To refuse experimental treatment and drugs. The patient's or health care decision maker's written consent for participation in research must be obtained and retained in his or her medical record;

(e) To have their records kept confidential and private. Written consent by the patient must be obtained prior to release of information except to persons authorized by law. If the patient lacks capacity, written consent is required from the patient's health care

RULES
OF
TENNESSEE DEPARTMENT OF HEALTH
BOARD FOR LICENSING HEALTH CARE FACILITIES

CHAPTER 1200-08-11
STANDARDS FOR HOMES FOR THE AGED

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1200-08-11-.01 DEFINITIONS.

(1) Abuse. The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.

(2) Activities of Daily Living (ADL's). Those personal functional activities which indicate an individual's independence in eating, dressing, personal hygiene, bathing, toileting, and moving from one place to another.

(3) Adult. An individual who has capacity and is at least 18 years of age.

(4) Advance Directive. An individual instruction or a written statement relating to the subsequent provision of health care for the individual, including, but not limited to, a living will or a durable power of attorney for health care.

(5) Aged. A person who is fifty-five (55) years of age or older.

(6) Agent. An individual designated in an advance directive for health care to make a health care decision for the individual granting the power.

(7) Ambulatory resident. A resident who is physically and mentally capable under emergency conditions of finding a way to safety without physical assistance from another person. An ambulatory resident may use a cane, wheelchair or other supportive device and may require verbal prompting.

(8) Board. The Tennessee Board for Licensing Health Care Facilities.

(9) Capacity. An individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision. These regulations do not affect the right of a resident to make health care decisions while having the capacity to do so. A resident shall be presumed to have capacity to make a health care decision, to give or revoke an advance directive, and to designate or disqualify a surrogate. Any person who challenges the capacity of a resident shall have the burden of proving lack of capacity.

(10) Cardiopulmonary Resuscitation (CPR). The administering of any means or device to restore or support cardiopulmonary function in a resident, whether by mechanical devices, chest compressions, mouth-to-mouth resuscitation, cardiac massage, tracheal intubation, manual

(Rule 1200-08-11-.01, continued)

or mechanical ventilators or respirations, defibrillation, the administration of drugs and/or chemical agents intended to restore cardiac and/or respiratory functions in a resident where cardiac or respiratory arrest has occurred or is believed to be imminent.

(11) Commissioner. The Commissioner of the Tennessee Department of Health or his or her authorized representative.

(12) Department. The Tennessee Department of Health.

(13) Designated Physician. A physician designated by an individual or the individual's agent, guardian, or surrogate, to have primary responsibility for the individual's health care or, in the absence of designation or if the designated physician is not reasonably available, a physician who undertakes such responsibility.

(14) Do-Not-Resuscitate Order (DNR). A written order, other than a POST, not to resuscitate a patient in cardiac or respiratory arrest in accordance with accepted medical practices.

(15) Emancipated Minor. Any minor who is or has been married or has by court order or otherwise been freed from the care, custody and control of the minor's parents.

(16) Emergency. Any situation or condition which presents an imminent danger of death or serious physical or mental harm to residents.

(16) Emergency responder. A paid or volunteer firefighter, law enforcement officer, or other public safety official or volunteer acting within the scope of his or her proper function under law or rendering emergency care at the scene of an emergency.

(18) Evacuation Capability. The ability to either evacuate the building or move to a point of safety.

(19) Guardian. A judicially appointed guardian of conservator having authority to make a health care decision

(20) Hazardous Waste. Materials whose handling, use, storage, and disposal are governed by local, state, or federal regulations.

(21) Health Care. Any care, treatment, service or procedure to maintain, diagnose, treat, or otherwise affect an individual's physical or mental condition, and includes medical care as defined in T.C.A. § 32-11-103(5)

(22) Health care decision. Consent, refusal or consent or withdrawal of consent to health care.

(23) Health Care Decision-maker. In the case of a resident who lacks capacity, the resident's health care decision-maker is one of the following: the resident's health care agent as specified in an advance directive, the resident's court-appointed guardian or conservator with healthcare decision-making authority, the resident's surrogate as determined pursuant to Rule 1200-08-11-.12 or T.C.A. § 33-3-220, the designated physician pursuant to these Rules or in the case of a minor child, the person having custody or legal guardianship.

(24) Health Care Institution. A health care institution as defined in T.C.A. § 68-11-1602.

(25) Health Care Provider A person who si licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care in the ordinary course of business or practice of a profession.

(Rule 1200-08-11-.01, continued)

(26) Holding Out to the Public. Advertising or soliciting the public through the use of personal, telephone, mail or other forms of communication to provide information about services provided by the facility.

(27) Home for the Aged. A home represented and held out to the general public as a home which accepts primarily aged persons for relatively permanent, domiciliary care with primarily being defined as 51% or more of the population of the home for the aged. It provides room, board and personal services to four (4) or more nonrelated persons. The term home includes any building or part thereof which provides services as defined in these rules.

(28) Home for the Aged Resident. A person who is ambulatory and who requires permanent, domiciliary care but who will be transferred to a licensed hospital, licensed nursing home or licensed assisted care living facility when health care services are needed which must be provided in such other facilities.

(29) Incompetent. A resident who has been adjudicated incompetent by a court of competent jurisdiction and has not been restored to legal capacity.

(28) Individual instruction. An individual's direction concerning a health care decision for the individual.

(30) Infectious Waste. Solid or liquid wastes which contain pathogens with sufficient virulence and quantity such that exposure to the waste by a susceptible host could result in an infectious disease.

(31) Licensee. The person or entity to whom the license is issued. The licensee is held responsible for compliance with all rules and regulations.

(32) Life Threatening Or Serious Injury. Injury requiring the patient to undergo significant additional diagnostic or treatment measures.

(33) Medically Inappropriate Treatment Resuscitation efforts that cannot be expected either to restore cardiac or respiratory function to the resident or other medical or surgical treatments to achieve the expressed goals of the informed resident. In the case of the incompetent resident, the resident's representative expresses the goals of the resident

(34) N.F.P.A. The National Fire Protection Association.

(35) Misappropriation of Patient/Resident Property. The deliberate misplacement, exploitation or wrongful, temporary or permanent use of an individual's belongings or money without the individual's consent.

(36) Neglect. The failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness; however, the withholding of authorization for or provision of medical care to any terminally ill person who has executed an irrevocable living will in accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of the living will, shall not be deemed "neglect" for purposes of these rules.

~~(37) Patient Abuse. Patient neglect, intentional infliction of pain, injury, or mental anguish. Patient abuse includes the deprivation of services by a caretaker which are necessary to maintain the health and welfare of a patient or resident; however, the withholding of authorization for or provision of medical care to any terminally ill person who has executed an irrevocable living will in accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of such living will shall not be deemed "patient abuse" for purposes of these rules.~~

(Rule 1200-08-11-.01, continued)

(37)~~(38)~~ Person. An individual, corporation, estate, trust, partnership, association, joint venture, government, governmental subdivision, agency or instrumentality, or any other legal or commercial entity.

(38)~~(39)~~ Personal Services. Those services that are rendered to residents who need supervision or assistance in activities of daily living. Personal services must include protective care of the resident, responsibility for the safety of the resident when in the facility, daily awareness of the resident's whereabouts and the ability and readiness to intervene if crises arise. Personal services do not include nursing or medical care.

(39)~~(40)~~ Personally Informing. A communication by any effective means from the resident directly to a health care provider.

(40)~~(41)~~ Physician Assistant. A person who has graduated from a physician assistant educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant, has passed the Physician Assistant National Certifying Examination, and is currently licensed in Tennessee as a physician assistant under title 63, chapter 19.

(41)~~(42)~~ Physician Orders for Scope of Treatment or POST. Written orders that:

(a) Are on a form approved by the Board for Licensing Health Care Facilities;

(b) Apply regardless of the treatment setting and that are signed as required herein by the patient's physician, physician assistant, nurse practitioner, or clinical nurse specialist; and

(c)

1. Specify whether, in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should or should not be attempted;

2. Specify other medical interventions that are to be provided or withheld; or

3. Specify both 1 and 2.

(42)~~(43)~~ Power of Attorney for Health Care. The designation of an agent to make health care decisions for the individual granting the power under T.C.A. Title 34, Chapter 6, Part 2

(43)~~(44)~~ Qualified Emergency Medical Service Personnel. Includes, but shall not be limited to, emergency services personnel providers, or entities acting within the usual course of their professions, and other emergency responders.

(44)~~(45)~~ Reasonably Available. Readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the resident's health care needs. Such availability shall include, but not limited to, availability by telephone.

(45)~~(46)~~ Responsible Attendant. The person designated by the licensee who remains awake to provide personal services to the residents. In the absence of the licensee, the responsible attendant is responsible for ensuring the home complies with all rules and regulations.

(46)~~(47)~~ Secured Unit. A facility or distinct part of a facility where the residents are intentionally denied egress by any means.

(47)~~(48)~~ Shall or Must. Compliance is mandatory.

(Rule 1200-08-11-.01, continued)

(48)~~(49)~~ State. A state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.

(49)~~(50)~~ Supervising Heath Care Provider. The designated physician or, if there is no designated physician ot the designated physician is not reasonably available, the health care provider who has undertaken primary responsibility for an individual's health care.

(50)~~(51)~~ Surrogate. An individual, other that a resident's agent or guardian, authorized to make a health care decision for the resident.

(51)~~(52)~~ Treating Health Care Provider. A health care provider who at the time is directly or indirectly involved in providing health care to the resident.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 39-11-106, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-216, 68-11-224, and 68-11-1802.* ***Administrative History:*** *Original rule filed June 21, 1979; effective August 6, 1979. Amendment filed August 16, 1988; effective September 30, 1988. Amendment filed January 30, 1992; effective March 15, 1992. Amendment filed December 7, 1993; effective February 20, 1994. Repeal and new rule filed July 27, 2000; effective October 10, 2000. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed April 28, 2003; effective July 12, 2003.Amendment filed September 8, 2006; effective November 22, 2006. Amendment filed February 7, 2007; effective April 23, 2007. Amendment filed February 23, 2007; effective May 9, 2007. Amendment filed January 3, 2012; effective April 2, 2012. Amendment filed March 27, 2015; effective June 25, 2015.*

1200-08-11-.02 LICENSING PROCEDURES.

(1) No person, partnership, association, corporation, or state, county or local government unit, or any division, department, board or agency thereof, shall establish, conduct, operate, or maintain in the State of Tennessee any home for the aged without having a license. A license shall be issued only to the applicant named and only for the premises listed in the application for licensure. Licenses are not transferable or assignable and shall expire and become invalid annually on the anniversary date of their original issuance. The license shall be conspicuously posted in the home for the aged.

(2) In order to make application for a license:

(a) The applicant shall submit an application on a form prepared by the department.

(b) Each applicant for a license shall pay an annual license fee based on the number of beds as follows:

1.	Less than 6 beds	$ 300.00
2.	6 to 24 beds, inclusive	$ 800.00
3.	25 to 49 beds, inclusive	$ 1,000.00
4.	50 to 74 beds, inclusive	$ 1,200.00
5.	75 to 99 beds, inclusive	$ 1,400.00
6.	100 to 124 beds, inclusive	$ 1,600.00
7.	125 to 149 beds, inclusive	$ 1,800.00
8.	150 to 174 beds, inclusive	$ 2,000.00

RULES
OF
TENNESSEE DEPARTMENT OF HEALTH
BOARD FOR LICENSING HEALTH CARE FACILITIES

CHAPTER 1200-08-25
STANDARDS FOR ASSISTED-CARE LIVING FACILITIES

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1200-08-25-.01 PURPOSE.

(1) The purpose of assisted-care living services is to:

(a) Promote the availability of appropriate residential facilities for the elderly and adults with disabilities in the least restrictive and most homelike environment;

(b) Provide assisted-care living services to residents in facilities by meeting each individual's medical and other needs safely and effectively; and

(c) Enhance the individual's ability to age in place while promoting personal individuality, respect, independence, and privacy.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 39-11-106, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-224, and 68-11-1802.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed November 25, 1998; effective February 8, 1999. Amendment filed September 13, 2002; effective November 27, 2002. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed April 28, 2003; effective July 12, 2003. Amendments filed January 24, 2006; effective April 9, 2006. Amendment filed February 7, 2007; effective April 23, 2007. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009.*

1200-08-25-.02 DEFINITIONS.

(1) "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.

(2) "Activities of Daily Living (ADL's)" means those activities which indicate an individual's independence in eating, dressing, personal hygiene, bathing, toileting, ambulating, and medication management.

(3) "Administering Medication" means the direct application of a single dose of medication to the body of a resident by injection, inhalation, ingestion, topical application or by any other means and the placement of a single dose of medication into a container.

(Rule 1200-08-25-.02, continued)

(4) "Administrator" means a natural person designated by the licensee to have the authority and responsibility to manage the ACLF and who is appropriately certified as an assisted-care living facility administrator or is currently licensed in Tennessee as a nursing home administrator as required by T.C.A. §§ 63-16-101, et seq.

(5) "Adult" means a person 18 years of age or older.

(6) "Ambulatory" means the resident's ability to bear weight, pivot and safely walk with the use of a cane, walker, or other mechanical supportive device with or without the minimal assistance of another person. The resident must be physically and mentally capable of self-preservation by evacuating in response to an emergency. A resident who requires a wheelchair must be capable of transferring to and propelling the wheelchair independently.

(7) "Assisted-care living facility (ACLF)" means a building, establishment, complex or distinct part thereof that accepts primarily aged persons for domiciliary care and services.

(8) "Assistance with Self-Administration of Medication" means assistance in reading labels, opening medication containers or packaging, reminding residents of their medication, or observing the resident while taking medication in accordance with the plan of care.

(9) "Assisted-care living facility resident" or "resident" means primarily an aged person who requires domiciliary care, and who upon admission to the facility, if not ambulatory, is capable of self-transfer from the bed to a wheelchair or similar device and is capable of propelling such wheelchair or similar device independently. Such a resident may require one or more of the following services: room and board, assistance with non-medical activities of daily living, administration of typically self-administered medications, and medical services subject to the limitations of these rules.

(10) "Assessment" means a procedure for determining the nature and extent of the problem(s) and needs of a resident or potential resident to ascertain if the ACLF can adequately address those problems, meet those needs, and secure information for the use in the development of the individual care plan.

(11) "Cardiopulmonary resuscitation (CPR)" means the administering of any means or device to restore or support cardiopulmonary functions in a resident, whether by mechanical devices, chest compressions, mouth-to-mouth resuscitation, cardiac massage, tracheal intubation, manual or mechanical ventilators or respirators, defibrillation, the administration of drugs and/or chemical agents intended to restore cardiac and/or respiratory functions in a resident where cardiac or respiratory arrest has occurred or is believed to be imminent.

(12) "Continuous nursing care" means round-the-clock observation, assessment, monitoring, supervision, or provision of nursing services that can only be performed by a licensed nurse.

(13) "Distinct part" means a unit or part thereof that is organized and operated to give a distinct type of care within the larger organization which renders other types or levels of care. "Distinct" denotes both organizational and physical separateness. A distinct part of an ACLF must be physically identifiable and be operated distinguishably from the rest of the institution. It must consist of all the beds within that unit such as a separate building, floor, wing or ward. Several rooms at one end of a hall or one side of a corridor is acceptable as a distinct part of an ACLF.

(14) "Do-Not-Resuscitate Order (DNR)" means a written order, other than a POST, not to resuscitate a patient in cardiac or respiratory arrest in accordance with accepted medical practices.

(Rule 1200-08-25-.02, continued)

(15) "Emergency" means any situation or condition which presents an imminent danger of death or serious physical or mental harm to residents.

(16) "Health care" means any care, treatment, service or procedure to maintain, diagnose, treat, or otherwise affect an individual's physical or mental condition, and includes medical care as defined in T.C.A. § 32-11-103(5).

(17) "Health care decision" means an individual's consent, refusal of consent or withdrawal of consent to health care.

(18) "Health care decision-maker" means that in the case of a resident who lacks capacity, the resident's health care decision-maker is one of the following: the resident's health care agent as specified in an advance directive, the resident's court-appointed guardian or conservator with health care decision-making authority, the resident's surrogate as determined pursuant T.C.A. § 68-11-1806, or the individual's designated physician pursuant to T.C.A. § 68-11-1802(a)(4).

(19) "Infectious waste" means solid or liquid wastes which contain pathogens with sufficient virulence and quantity such that exposure could result in an infectious disease.

~~(20) "Licensed health care professional" means any health care professional currently licensed by the State of Tennessee to practice within the scope of a regulated profession, such as a nurse practitioner, registered nurse, licensed practical nurse, (nurses may be licensed or hold multistate licensure pursuant to Tennessee Code Annotated §§ 63-7-101 et seq.), dietitian, dentist, occupational therapist, pharmacist, physical therapist, physician, physician assistant, psychologist, clinical social worker, speech-language pathologist, and emergency service personnel.~~

(20) "Licensed health care professional" means:

(a) Any health care professional currently licensed by the State of Tennessee to practice within the scope of a regulated profession, such as a nurse practitioner, dietitian, dentist, occupational therapist, pharmacist, physical therapist, physician, physician assistant, psychologist, social worker, speech-language pathologist, and emergency service personnel; or

(b) A medication aide (as defined in Tennessee Code Annotated § 63-7-127).

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(21) "Licensee" means the person, association, partnership, corporation, company or public agency to which the license is issued.

(22) "Life threatening or serious injury" means an injury requiring the resident to undergo significant diagnostic or treatment measures.

(23) "Medical record" means documentation of medical histories, nursing and treatment records, care needs summaries, physician orders, and records of treatment and medication ordered and given which must be maintained by the ACLF, regardless of whether such services are rendered by ACLF staff or by arrangement with an outside source.

(24) "Medically inappropriate treatment" means resuscitation efforts that cannot be expected either to restore cardiac or respiratory function to the resident or other medical or surgical treatments that cannot be expected to achieve the expressed goals of the informed resident.

(25) "Medication Aide" means an individual who administers medications, as set forth in

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(Rule 1200-08-25-.02, continued)

Tennessee Code Annotated § 63-7-127, under the general supervision of a licensed nurse pursuant to this section.

(26)~~(25)~~ "Misappropriation of patient/resident property" means the deliberate misplacement, exploitation or wrongful, temporary or permanent use of an individual's belongings or money without the individual's consent.

(27)~~(26)~~ "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness; however, the withholding of authorization for or provision of medical care to any terminally ill person who has executed an irrevocable living will in accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of the living will, shall not be deemed "neglect" for purposes of these rules.

(28)~~(27)~~ "NFPA" means the National Fire Protection Association.

(29)~~(28)~~ "Person" means an individual, association, estate, trust, corporation, partnership, joint venture, government, governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

(30)~~(29)~~ "Personal services" means those services rendered to residents who need supervision or assistance in activities of daily living. Personal services do not include nursing or medical care.

(31)~~(30)~~ "Physician Assistant" means a person who has graduated from a physician assistant educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant, has passed the Physician Assistant National Certifying Examination, and is currently licensed in Tennessee as a physician assistant under title 63, chapter 19.

(32)~~(31)~~ "Physician Orders for Scope of Treatment" or "POST" means written orders that:

(a) Are on a form approved by the Board for Licensing Health Care Facilities;

(b) Apply regardless of the treatment setting and that are signed as required herein by the patient's physician, physician assistant, nurse practitioner, or clinical nurse specialist; and

(c)

1. Specify whether, in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should or should not be attempted;

2. Specify other medical interventions that are to be provided or withheld; or

3. Specify both 1 and 2.

(33)~~(32)~~ "Power of Attorney for Health Care" means the legal designation of an agent to make health care decisions for the individual granting such power under T.C.A. Title 34, Chapter 6, Part 2.

(34)~~(33)~~ "Primarily aged" means that a minimum of fifty-one percent (51%) of the population of the facility is at least sixty- two (62) years of age.

(Rule 1200-08-25-.02, continued)

(35)~~(34)~~ "Resident sleeping unit" means a single unit providing sleeping facilities for one or more persons. Resident sleeping units can also include permanent provisions for living, eating and sanitation.

(36)~~(35)~~ "Responsible attendant" means the individual person designated by the licensee to provide personal services to the residents.

~~(36) "Secured unit" means a distinct part of an ACLF where the residents are intentionally denied egress by any means.~~

(37) "Secured unit" means a distinct part of an ACLF where the residents are intentionally denied egress except as is necessary to comply with life safety requirements.

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(38)~~(37)~~ "Self-Administration of Medication" means the ability to administer medicine to oneself without assistance other than receiving help with reading labels or with physically opening the container or packaging, being reminded of one's medication, or being observed while taking medication in accordance with the plan of care.

(39)~~(38)~~ "Supervising health care provider" means the health care provider who has undertaken primary responsibility for an individual's health care.

(40)~~(39)~~ "Surrogate" means an individual, other than a resident's agent or guardian, authorized to make a health care decision for the resident pursuant to T.C.A. § 68-11-1806.

(41)~~(40)~~ "Treating health care provider" means a health care provider directly or indirectly involved in providing health care to a resident at the time such care is needed by the resident.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-210, and 68-11-211.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed November 19, 2003; effective February 2, 2004. Amendment filed January 19, 2007; effective April 4, 2007. Amendment filed February 23, 2007; effective May 9, 2007. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009. Amendment filed January 3, 2012; effective April 2, 2012. Amendment filed March 27 2015; effective June 25, 2015.*

1200-08-25-.03 LICENSING REQUIREMENTS.

(1) An applicant for an ACLF license shall submit the following to the office of the Board for Licensing Health Care Facilities:

(a) A completed application on a form approved by the Board;

(b) Nonrefundable application fee;

(c) Demonstration of the ability to meet the financial obligations of the ACLF with a financial statement prepared by a certified public accountant;

(d) A copy of a local business license (if one is required by the locality);

(e) A copy of any and all documents demonstrating the legal status of the business organization that owns the ACLF. If the applicant is a corporation or a limited liability company the applicant must submit a certificate of good standing; and

(Rule 1200-08-25-.03, continued)

(f) Any other documents or information requested by the Board.

(2) Before a license is granted, the applicant shall submit to an inspection conducted by Department of Health inspectors to ensure compliance with all applicable laws and rules.

(3) The applicant shall not use subterfuge or other evasive means to obtain a license, such as filing for a license through a second party when an applicant has been denied a license or has had a license disciplined or has attempted to avoid the survey and review process.

(4) ACLF licenses shall expire and become invalid annually on the anniversary date of their original issuance.

(a) In order to successfully renew a license, Department inspectors will periodically inspect each ACLF to determine its compliance with these rules and regulations. If the inspectors find deficiencies, the licensee shall submit an acceptable corrective action plan and shall remedy the deficiencies.

(b) If a licensee fails to renew its license prior to the date of its expiration but submits the renewal form and fee within sixty (60) days thereafter, the licensee may renew late by paying, in addition to the renewal fee, a late penalty of one hundred dollars ($100) per month for each month or fraction of a month that renewal is late; provided that the late penalty shall not exceed twice the renewal fee.

(c) In the event that a licensee fails to renew its license within the sixty (60) day grace period following the license expiration date, then the licensee shall reapply for a license by submitting the following to the Board office:

1. A completed application for licensure; and

2. The license fee provided in rule 1200-08-25-.04(1).

(d) Upon reapplication, the licensee shall submit to an inspection of the ACLF by Department of Health inspectors.

(5) The Board shall issue a license only for the licensee and the location designated on the license application. If an ACLF moves to a new location, it shall obtain a new license and submit to an inspection of the new building before admitting residents.

(6) A separate license shall be required for each ACLF when more than one facility is operated under the same management or ownership.

(7) Any admission in excess of the licensed bed capacity is prohibited.

(8) Change of Ownership.

(a) A change of ownership occurs whenever the ultimate legal authority for the responsibility of the ACLF's operation is transferred, including a change in the legal structure by which the ACLF is owned and operated, and/or whenever ownership of the preceding or succeeding entity changes.

(b) A licensee shall notify the Board's administrative office of a proposed change of ownership within at least thirty (30) days prior to its occurrence by submitting the following to the Board office:

1. A completed change of ownership application on a form approved by the Board;

(Rule 1200-08-25-.03, continued)

2. Nonrefundable application fee;

3. Demonstration of ability to meet the financial obligations of the ACLF with a financial statement prepared by a certified public accountant;

4. A copy of a local business license (if one is required by the locality);

5. A copy of any and all documents demonstrating the formation of the business organization that owns the ACLF;

6. The bill of sale and/or closing documents indicating the transfer of operations of the business entity; and

7. Any other documents or information requested by the Board.

(c) Transactions constituting a change of ownership include, but are not limited to, the following:

1. Transfer of the ACLF's legal title;

2. Lease of the ACLF's operations;

3. Dissolution of any partnership that owns, or owns a controlling interest in, the ACLF;

4. The removal, addition or substitution of a partner;

5. Removal of the general partner or general partners, if the ACLF is owned by a limited partnership;

6. Merger of an ACLF owner (a corporation) into another corporation where, after the merger, the owner's shares of capital stock are canceled;

7. The consolidation of a corporate ACLF owner with one or more corporations; or

8. Transfers between levels of government.

(d) Transactions which do not constitute a change of ownership include, but are not limited to, the following:

1. Changes in the membership of a corporate board of directors or board of trustees;

2. Merger of two (2) or more corporations where one of the originally-licensed corporations survives;

3. Changes in the membership of a non-profit corporation;

4. Transfers between departments of the same level of government;

5. Corporate stock transfers or sales, even when a controlling interest.

6. Sale/lease-back agreements if the lease involves the ACLF's entire real and personal property and if the identity of the lessee, who shall continue the operation, retains the same legal form as the former owner; or

(Rule 1200-08-25-.03, continued)

7. Management agreements if the owner continues to retain ultimate authority for the operation of the ACLF; however, if the ultimate authority is surrendered and transferred from the owner to a new manager, then a change of ownership has occurred.

(9) Certification of Administrator

(a) Each ACLF must have an administrator who shall be certified by the Board, unless the administrator is currently licensed in Tennessee as a nursing home administrator as required by T.C.A. § 63-16-101, *et seq.*

(b) An applicant for certification as an ACLF administrator shall submit the following to the Board office:

1. A completed application on a form approved by the Board;

2. Nonrefundable application fee;

3. ~~Proof that the applicant is at least eighteen (18) years of age;~~

3. Proof that the applicant is at least twenty-one (21) years of age;

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4. Proof that the applicant is a high school graduate or the holder of a general equivalency diploma;

5. Results of a criminal background check; and

6. Proof that the applicant has not been convicted of a criminal offense involving the abuse or intentional neglect of an elderly or vulnerable individual.

(c) Renewal of ACLF administrator certification.

1. Certification shall be renewed biennially on June 30.

2. The initial biennial re-certification expiration date of ACLF administrator candidates who receive their first certification between the dates of January 1 and June 30 of any year will be extended to two (2) years plus the additional months remaining in the fiscal year.

3. In order to renew certification, the ACLF administrator shall submit the following to the Board office: renewal application; fee established by rule 1200-08-25-.04; and proof of having obtained at least twenty-four (24) classroom hours of continuing education during the previous two (2) years.

4. An ACLF administrator shall complete twenty-four (24) classroom hours of continuing education approved by the Board prior to attendance, including, but not limited to the following topics:

(i) State rules and regulations for ACLFs;

(ii) Health care management;

(iii) Nutrition and food service;

(iv) Financial management; and

(Rule 1200-08-25-.03, continued)

(v) Healthy lifestyles.

5. All educational courses sponsored by the National Association of Boards of Examiners for Nursing Home Administrators (NAB) and continuing education courses sponsored by State and/or national associations that focus on geriatric care are board approved.

6. An ACLF administrator who allows an administrator certification to lapse and reapplies for new certification must submit written proof of attendance of at least twenty-four (24) classroom hours of continuing education courses, as described in Part 4 above, within six (6) months after submitting a new application.

(10) The licensee shall immediately notify the Board's administrative office in the event of an absence or change of administrator due to serious illness, incapacity, death or resignation of its named administrator.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 4-5-219, 4-5-312, 4-5-316, 4-5-317, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-208, 68-11-209, 68-11-213, 68-11-216, and Chapter 846 of the Public Acts of 2008, § 1.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed March 1, 2007; effective May 15, 2007. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009. Amendment filed December 16, 2013; effective March 16, 2014.*

1200-08-25-.04 FEES.

(1) Each ACLF, except those operated by the United States of America or the State of Tennessee, making application for licensure under this chapter shall pay annually to the Board's administrative office, a fee based on the number of ACLF beds, as follows:

(a)	Less than 25 beds	$ 800.00
(b)	25 to 49 beds, inclusive	$ 1,000.00
(c)	50 to 74 beds, inclusive	$ 1,200.00
(d)	75 to 99 beds, inclusive	$ 1,400.00
(e)	100 to 124 beds, inclusive	$ 1,600.00
(f)	125 to 149 beds, inclusive	$ 1,800.00
(g)	150 to 174 beds, inclusive	$ 2,000.00
(h)	175 to 199 beds, inclusive	$ 2,200.00

For ACLFs of two hundred (200) beds or more, the fee shall be two thousand four hundred dollars ($2,400.00) plus two hundred dollars ($200.00) for each twenty-five (25) beds or fraction thereof in excess of one hundred ninety-nine (199) beds. The fee shall be submitted with the application or renewal and is not refundable.

(2) Each ACLF administrator shall submit to the Board's administrative office an application fee of one hundred eighty dollars ($180.00). The fee shall be submitted with the initial application or renewal application and is not refundable.

(Rule 1200-08-25-.06, continued)

(i) Types of resident care activities that can result in hand contamination;

(ii) Advantages and disadvantages of various methods used to clean hands;

(iii) Potential risks of health care workers' colonization or infection caused by organisms acquired from residents; and

(iv) Morbidity, mortality, and costs associated with health care associated infections.

(d) An ACLF shall develop and implement a system for measuring improvements in adherence to the hand hygiene program and influenza vaccination program.

(6) An ACLF shall ensure that no person will be excluded from participation in, be denied benefits of, or be otherwise subjected to discrimination in the provision of any care or service of the ACLF on the grounds of race, color, national origin, or handicap. An ACLF shall protect the civil rights of residents under the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

Authority: *T.C.A. §§ 39-17-1804, 39-17-1805, 68-3-511, 4-5-202, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-254, 68-11-268, and 71-6-121.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed January 7, 2000; effective March 22, 2000. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009. Amendment filed March 27, 2015; effective June 25, 2015. Amendments filed July 18, 2016; effective October 16, 2016.*

1200-08-25-.07 SERVICES PROVIDED.

(1) An ACLF may provide medical services as follows:

(a) Administer medications to residents that are typically self-administered as subject to limitations described within these rules and regulations.

(b) All other medical services prescribed by the physician that could be provided to a private citizen in the citizen's home, including, but not limited to:

1. Part-time or intermittent nursing care;

2. Various therapies;

3. Podiatry care;

4. Medical social services;

5. Medical supplies;

6. Durable medical equipment; and

7. Hospice services.

(c) Intravenous medications may only be administered to:

1. Existing residents who receive them on an intermittent basis; and

(Rule 1200-08-25-.07, continued)

2. Residents receiving hospice care.

(2) Medical services in an ACLF shall be provided by:

(a) Appropriately licensed or qualified staff of an ACLF;

(b) Appropriately licensed or qualified contractors of an ACLF;

(c) A licensed home care organization;

(d) Another appropriately licensed entity; or

(e) Appropriately licensed staff of a nursing home.

(3) Oversight of medical services in an ACLF shall be consistent with oversight provided in private residential settings as defined through rules and regulations promulgated by the applicable licensing boards and shall ensure quality of care to residents.

(4) Medicare reimbursable services shall be provided to an ACLF resident by a certified Medicare provider.

(5) Resident medication. An ACLF shall:

(a) Ensure that medication shall be self-administered in accordance with the resident's plan of care;

~~(b) Ensure that all drugs and biologicals shall be administered by a licensed professional operating within the scope of the professional license and according to the resident's plan of care; and~~

~~(c) Store all medications so that no resident can obtain another resident's medication.~~

(b) Ensure that all drugs and biologicals shall be administered by a licensed or certified health care professional operating within the scope of the professional license or certification and according to the resident's plan of care.

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(c) Ensure that during the course of administering medication, a medication aide shall not be assigned any other non-medication administration duties. However, a medication aide shall not be precluded from responding, as appropriate, to an emergency;

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(d) Store all medications via a locked or closed container and/or room which includes, but is not limited to, some type of box, piece of furniture, an individual resident room, and/or a designated room within the facility which maintains resident medication out of the sight of other residents; and

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(e) Ensure that facility staff shall not repackage medication and shall not administer medication from repackaging.

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(6) An ACLF shall dispose of medications as follows:

(a) Upon discharge of a resident, unused prescription medication shall be released to the resident, the resident's family member, or the resident's legal representative, unless specifically prohibited by the attending physician.

(Rule 1200-08-25-.07, continued)

(b) Upon death of a resident, unused prescription medication must be destroyed in the manner outlined, and by the individuals designated, in the facility's medication disposal policy, unless otherwise requested by the resident's family member or the resident's legal representative and accompanied by a written order by a physician. The ACLF's medication disposal policy shall be written in accordance with current FDA or current DEA medication disposal guidelines.

(c) The ACLF shall properly dispose of prescription medication administered by the facility in accordance with the facility's medication disposal policy, which shall be written in accordance with current FDA or current DEA medication disposal guidelines.

(d) The ACLF may dispose of prescription medication that is self-administered by the resident according to the facility's medication disposal policy, which shall be written in accordance with current FDA or current DEA medication disposal guidelines, or the facility may provide information to the resident's family member or the resident's legal representative regarding the proper method to dispose of the medication.

(e) If the resident is a hospice patient, hospice shall be responsible for disposing of the prescription medication upon the death of the resident.

~~(f) The ACLF's medication disposal policy shall be performed by one (1) licensed health care professional and either the facility's administrator, a second licensed health care professional, or a medication aide certified.~~

(f) The ACLF's medication disposal policy shall be performed by a licensed or certified health care professional and either the facility's administrator, or a second licensed or certified health care professional.

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(g) The ACLF's medication disposal policy shall also address the disposal of scheduled drugs, non-scheduled drugs, and devices that are misbranded, expired, deteriorated, not kept under proper conditions, and kept in containers with illegible or missing labels.

(7) An ACLF shall provide personal services as follows:

(a) Each ACLF shall provide each resident with at least the following personal services:

1. Protective care;
2. Safety when in the ACLF;
3. Daily awareness of the individual's whereabouts;
4. The ability and readiness to intervene if crises arise;
5. Room and board; and
6. Non-medical living assistance with activities of daily living.

(b) Laundry services. An ACLF shall:

1. Provide arrangements for laundry of ACLF linens and residents' clothing;
2. Provide appropriate separate storage areas for soiled linens and residents' clothing; and

(Rule 1200-08-25-.07, continued)

3. Maintain clean linens in sufficient quantity to provide for the needs of the residents. Linens shall be changed whenever necessary.

(c) Dietary services.

1. An ACLF shall have organized dietary services that are directed and staffed by adequate qualified personnel. An ACLF may contract with an outside food management company if the company has a dietitian who serves the ACLF on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section while providing for constant liaison with the ACLF for recommendations on dietetic policies affecting resident treatment.

2. An ACLF shall have an employee who:

(i) Serves as director of the food and dietetic service;

(ii) Is responsible for the daily management of the dietary services and staff training; and

(iii) Is qualified by experience or training.

3. An ACLF shall ensure that menus meet the needs of the residents as follows:

(i) The practitioner or practitioners, as qualified within the scope of practice, responsible for the care of the residents shall prescribe therapeutic diets as necessary.

(ii) An ACLF shall meet nutritional needs, in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of the residents.

(iii) An ACLF shall have a current therapeutic diet manual approved by the dietitian readily available to all ACLF personnel.

(iv) Menus shall be planned one week in advance.

4. An ACLF shall:

(i) Provide at least three (3) meals constituting an acceptable and/or prescribed diet per day. There shall be no more than fourteen (14) hours between the evening and morning meals. All food served to the residents shall be of good quality and variety, sufficient quantity, attractive and at safe temperatures. Prepared foods shall be kept hot (140°F. or above) or cold (41°F. or less) as appropriate. The food must be adapted to the habits, preferences and physical abilities of the residents. Additional nourishment and/or snacks shall be provided to residents with special dietary needs or upon request.

(ii) Provide sufficient food provision capabilities and dining space.

(iii) Maintain and properly store a forty-eight (48) hour food supply at all times.

(iv) Provide appropriate, properly-repaired equipment and utensils for cooking and serving food in sufficient quantity to serve all residents.

(Rule 1200-08-25-.07, continued)

5. An ACLF shall maintain a clean and sanitary kitchen.

6. Employees shall wash and sanitize equipment, utensils and dishes after each use.

(d) An ACLF shall provide a suitable and comfortable furnished area for activities and family visits. Furnishings shall include a calendar and a functioning television set, radio, and clock.

(e) An ACLF shall provide current newspapers, magazines or other reading materials.

(f) An ACLF shall have a telephone accessible to all residents to make and receive personal telephone calls twenty-four (24) hours per day.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-261.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed November 25, 1999; effective February 8, 1999. Amendment filed August 26, 2002; effective November 9, 2002. Amendment filed February 18, 2003; effective May 4, 2003. Repeal and new rule filed January 24, 2006; effective April 9, 2006. Amendment filed February 23, 2007; effective May 9, 2007. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009. Amendment filed March 27, 2015; effective June 25, 2015.*

1200-08-25-.08 ADMISSIONS, DISCHARGES, AND TRANSFERS.

(1) An ACLF shall not admit or permit the continued stay of any ACLF resident who has any of the following conditions:

(a) Requires treatment for stage III or stage IV decubitus ulcers or with exfoliative dermatitis;

(b) Requires continuous nursing care;

(c) Has an active, infectious and reportable disease in a communicable state that requires contact isolation;

(d) Exhibits verbal or physical aggressive behavior which poses an imminent physical threat to self or others, based on behavior, not diagnosis;

(e) Requires physical or chemical restraints, not including psychotropic medications for a manageable mental disorder or condition; or

(f) Has needs that cannot be safely and effectively met in the ACLF.

(2) An ACLF resident shall be discharged and transferred to another appropriate setting such as home, a hospital, or a nursing home when the resident, the resident's legal representative, ACLF administrator, or the resident's treating physician determine that the ACLF cannot safely and effectively meet the resident's needs, including medical services.

(a) The Board may require that an ACLF resident be discharged or transferred to another level of care if it determines that the resident's needs, including medical services, cannot be safely and effectively met in the ACLF.

(3) Except for the limitations set forth in (4)(a) and (4)(b) of this rule, an ACLF may admit and permit the continued stay of an individual meeting the level of care requirement for nursing facility services, if:

(Rule 1200-08-25-.08, continued)

(a) The resident's treating physician certifies in writing that the resident's needs, including medical services, can be safely and effectively met by care provided in the ACLF; and

(b) The ACLF can provide assurances that the resident can be timely evacuated in case of fire or emergency.

(4) An ACLF shall not admit, but may permit the continued stay of residents who require:

(a) The following treatments on an intermittent basis of up to three (3) twenty-one (21) day periods. The resident's treating physician must certify that treatment can be safely and effectively provided by the ACLF for the last two (2) twenty-one (21) day periods.

1. Nasopharyngeal or tracheotomy aspiration;

2. Nasogastric feedings;

3. Gastrostomy feedings; or

4. Intravenous therapy or intravenous feedings.

(b) The treatments described in parts (1)-(4) above can be provided on an on-going basis if:

1. The resident is receiving hospice services;

2. The resident does not qualify for nursing facility level care and the board grants a waiver; or

3. The resident is able to care for the specified conditions without assistance of facility personnel or other appropriately licensed entity. Such a resident may be admitted or permitted to continue as a resident of the ACLF.

(5) An ACLF resident qualifying for hospice care shall be able to receive hospice care services and continue as a resident if the resident's treating physician certifies that such care can be appropriately provided in the ACLF.

(a) In the event that the resident is able to receive hospice services in an ACLF, the resident's hospice provider and the ACLF shall be jointly responsible for a plan of care that is prepared pursuant to current hospice guidelines promulgated by the Centers for Medicaid and Medicare and ensures both the safety and well-being of the resident's living environment and provision of the resident's health care needs.

(b) The hospice provider shall be available to assess, plan, monitor, direct and evaluate the resident's palliative care with the resident's treating physician and in cooperation with the ACLF.

(6) An ACLF shall:

(a) Be able to identify at the time of admission and during continued stay those residents whose needs for services are consistent with these rules and regulations, and those residents who should be transferred to a higher level of care;

(b) Have a written admission agreement that includes a procedure for handling the transfer or discharge of residents and that does not violate the residents' rights under the law or these rules;

(Rule 1200-08-25-.08, continued)

(c) Have an accurate written statement regarding fees and services which will be provided residents upon admission;

(d) Give a thirty (30) day notice to all residents before making any changes in fee schedules;

(e) Ensure that residents see a physician for acute illness or injury and are transferred in accordance with any physician's orders;

(f) Provide to each resident at the time of admission a copy of the resident's rights for the resident's review and signature;

(g) Have written policies and procedures to assist residents in the proper development, filing, modification and rescission of an advance directive, a living will, a do-not-resuscitate order, and the appointment of a durable power of attorney for health care;

(h) Prior to the admission of a resident or prior to the execution of a contract for the care of a resident (whichever occurs first), each ACLF shall disclose in writing to the resident or to the resident's legal representative, whether the ACLF has liability insurance and the identity of the primary insurance carrier. If the ACLF is self-insured, its statement shall reflect that fact and indicate the corporate entity responsible for payment of any claims;

(i) Document evidence of annual vaccination against influenza for each resident, in accordance with the recommendation of the Advisory Committee on Immunization Practices of the Centers for Disease Control most recent to the time of vaccine, unless such vaccination is medically contraindicated or the resident has refused the vaccine. Influenza vaccination for all residents accepting the vaccine shall be completed by November 30 of each year or within ten (10) days of the vaccine becoming available. Residents admitted after this date during the flu season and up to February 1, shall as medically appropriate, receive influenza vaccination prior to or on admission unless refused by the resident; and

(j) Document evidence of vaccination against pneumococcal disease for all residents who are sixty-five (65) years of age or older, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control at the time of vaccination, unless such vaccination is medically contraindicated or the resident has refused offer of the vaccine. The facility shall provide or arrange the pneumococcal vaccination of residents who have not received this immunization prior to or on admission unless the resident refuses offer of the vaccine.

(k) Prior to the admission of a resident or prior to the execution of a contract for the care of a resident (whichever occurs first), each ACLF shall disclose in writing to the resident or to the resident's legal representative a copy of the medication disposal policy, which shall be written in accordance with current FDA or current DEA medication disposal guidelines.

(7) An ACLF shall have documented plans and procedures to show evacuation of all residents.

(8) An ACLF may not retain a resident who cannot evacuate within thirteen (13) minutes unless the ACLF complies with Chapter 19 of the 2006 edition of the NFPA Life Safety Code, and the Institutional Unrestrained Occupancy of the 2006 edition of the International Building Code.

(Rule 1200-08-25-.08, continued)

(9) An ACLF utilizing secured units shall provide survey staff with twelve (12) months of the following performance information specific to the secured unit and its residents at its annual survey:

~~(a) Documentation that an interdisciplinary team consisting of at least a physician, a social worker, a registered nurse, and a family member (or patient care advocate) has evaluated each secured resident prior to admittance to the unit;~~

(a) Documentation that an interdisciplinary team consisting of at least a physician, a registered nurse, and a family member (or patient care advocate) has evaluated each secured resident prior to admittance to the unit;

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(b) Ongoing and up-to-date documentation that each resident's interdisciplinary team has performed a quarterly review as to the appropriateness of placement in the secured unit;

(c) A current listing of the number of deaths and hospitalizations, with diagnoses, that have occurred on the unit;

(d) A current listing of all unusual incidents and/or complications on the unit;

(e) An up-to-date staffing pattern and staff ratios for the unit that is recorded on a daily basis. The staffing pattern must ensure that there is a minimum of one (1) attendant, awake, on duty, and physically located on the unit twenty-four (24) hours per day, seven (7) days per week, at all times;

(f) A formulated calendar of daily group activities scheduled, including a resident attendance record for the previous three (3) months;

(g) An up-to-date listing of any incidences of decubitus and/or nosocomial infections, including resident identifiers; and

(h) Documentation showing that 100% of the staff working on the unit receives annual in-service training which shall include, but not be limited to, the following subject areas:

1. Basic facts about the causes, progression and management of Alzheimer's disease and related disorders;

2. Dealing with dysfunctional behavior and catastrophic reactions in the residents;

3. Identifying and alleviating safety risks to the resident;

4. Providing assistance in the activities of daily living for the resident; and

5. Communicating with families and other persons interested in the resident.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-201(5), 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-211, 68-11-263, and 68-11-266.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed January 7, 2000; effective March 22, 2000. Amendment filed February 18, 2003; effective May 4, 2003. Repeal and new rule filed January 24, 2006; effective April 9, 2006. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009. Amendment filed March 27, 2015; effective June 25, 2015.*

1200-08-25-.09 BUILDING STANDARDS.

(Rule 1200-08-25-.09, continued)

(b) Generators (if applicable).

(26) Each ACLF shall ensure that an emergency keyed lock box is installed next to each bank of functioning elevators located on the main level. Such lock boxes shall be permanently mounted seventy-two inches (72") from the floor to the center of the box, be operable by a universal key no matter where such box is located, and shall contain only fire service keys and drop keys to the appropriate elevators.

Authority: *T.C.A. §§ 4-5-202, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-261.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009. Amendments filed December 20, 2011; effective March 19, 2012. Amendment filed January 21, 2016; effective April 20, 2016.*

1200-08-25-.10 LIFE SAFETY.

(1) The department will consider any ACLF that complies with the required applicable building and fire safety regulations at the time the Board adopts new codes or regulations, so long as such compliance is maintained (either with or without waivers of specific provisions), to be in compliance with the requirements of the new codes or regulations.

(2) An ACLF shall ensure fire protection for residents by doing at least the following:

(a) Eliminate fire hazards;

(b) Install necessary fire fighting equipment;

(c) Adopt a written fire control plan;

(d) Ensure that each resident sleeping unit shall have a door that opens directly to the outside or to a corridor which leads directly to an exit door and that is always capable of being unlocked by the resident;

(e) Ensure that louvers shall not be present in doors to residents' sleeping units;

(f) Keep corridors and exit doors clear of equipment, furniture and other obstacles at all times. Passage to exit doors leading to a safe area shall be clear at all times;

(g) Prohibit use of combustible finishes and furnishings;

(h) Prohibit open flame and portable space heaters;

~~(i) Prohibit cooking appliances other than microwave ovens in resident sleeping units;~~

(i) Ensure that upon entering the ACLF, the resident or his or her responsible party is asked if they wish to have a cooking appliance that is appropriate for their level of cognition. If the facility chooses to provide a requested cooking appliance, it shall be used in accordance with the facility's policies. If the resident or his or her responsible party wishes to provide their own cooking appliance, it shall meet the facility's policies and safety standards. The cooking appliances shall be designed so that they can be disconnected and removed for resident safety or if the resident chooses not to have cooking capability within his or her apartment. The cooking appliances shall have an automatic timer.

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(Rule 1200-08-25-.10, continued)

(j) Ensure that all heaters shall be guarded and spaced to prevent ignition of combustible material and accidental burns. The guard shall not have a surface temperature greater than 120°F;

(k) Allow use of fireplaces and/or fireplace inserts only if the ACLF ensures that they have guards or screens which are secured in place;

(l) Inspect and clean fireplaces and chimneys annually and maintain documentation that such inspection has occurred;

(m) Ensure that there are electrically-operated smoke detectors with battery back-up power operating at all times in, at least, resident sleeping units, day rooms, corridors, laundry room, and any other hazardous areas; and

~~(n) Provide and mount fire extinguishers, complying with NFPA 10, so they are accessible to all residents in the kitchen, laundries and at all exits. Extinguishers in the kitchen and laundries shall be a minimum of 2-A: 10-BC and an extinguisher with a rating of 20-A shall be adjacent to every hazardous area. The minimum travel distance shall not exceed fifty (50) feet between the extinguishers.~~

(n) Provide and mount fire extinguishers and maintain travel distance between fire extinguishers, complying with NFPA 10, so they are accessible to all residents in the kitchen, laundries and at all exits.

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(3) An ACLF shall conduct fire drills in accordance with the following:

(a) Fire drills shall be held for each ACLF work shift in each separate ACLF building at least quarterly;

(b) There shall be one (1) fire drill per quarter during sleeping hours;

(c) An ACLF shall prepare a written report documenting the evaluation of each drill that includes the action that is recommended or taken to correct any deficiencies found; and,

(d) An ACLF shall maintain records that document and evaluate these drills for at least three (3) years.

(4) An ACLF shall take the following action should a fire occur:

(a) An ACLF shall report all fires which result in a response by the local fire department to the department within seven (7) days of its occurrence.

(b) An ACLF's report to the department shall contain the following:

1. Sufficient information to ascertain the nature and location of the fire;

2. Sufficient information to ascertain the probable cause of the fire; and

3. A list and description of any injuries to any person or persons as a result of the fire.

4. An ACLF may omit the name(s) of resident(s) and parties involved in initial reports. Should the department later find the identities of such persons to be necessary to an investigation, the ACLF shall provide such information.

(Rule 1200-08-25-.10, continued)

(5) An ACLF shall take the following precautions regarding electrical equipment to ensure the safety of residents:

(a) Provide lighted corridors at all times, to a minimum of one foot candle;

(b) Provide general and night lighting for each resident and equip night lighting with emergency power;

(c) Maintain all electrical equipment in good repair and safe operating condition;

(d) Ensure that electrical cords shall not run under rugs or carpets;

(e) Ensure that electrical systems shall not be overloaded;

(f) Ensure that power strips are equipped with circuit breakers; and

(g) Prohibit use of extension cords.

(6) If an ACLF allows residents to smoke, it shall ensure the following:

(a) Permit smoking and smoking materials only in designated areas under supervision;

(b) Provide ashtrays wherever smoking is permitted;

(c) Smoking in bed is prohibited;

(d) Written policies and procedures for smoking within the ACLF shall designate a room or rooms to be used exclusively for residents who smoke. The designated smoking room or rooms shall not be the dining room, the activity room, or an individual resident sleeping unit, and;

(e) Post no smoking signs in areas where oxygen is used or stored.

(7) An ACLF shall not allow trash and other combustible waste to accumulate within and around the ACLF. It shall store trash in appropriate containers with tight-fitting lids. An ACLF shall furnish resident sleeping units with an UL approved trash container.

(8) An ACLF shall ensure that:

(a) The ACLF maintains all safety equipment in good repair and in a safe operating condition;

(b) The ACLF stores janitorial supplies away from the kitchen, food storage area, dining area or other resident accessible areas;

(c) The ACLF stores flammable liquids in approved containers and away from the facility living areas; and

(d) The ACLF cleans floor and dryer vents as frequently as needed to prevent accumulation of lint, soil and dirt.

(9) An ACLF shall post emergency telephone numbers near a telephone accessible to the residents.

(10) An ACLF shall maintain its physical environment in a safe, clean and sanitary manner by doing at least the following:

(Rule 1200-08-25-.10, continued)

(a) Prohibit any condition on the ACLF site conducive to the harboring or breeding of insects, rodents or other vermin;

(b) Properly identify chemical substances of a poisonous nature used to control or eliminate vermin and store such substances away from food or medications;

(c) Ensure that the building shall not become overcrowded with a combination of the ACLF's residents and other occupants;

(d) Ensure that each resident sleeping unit shall contain a chair, bed, mattress, springs, linens, chest of drawers and wardrobe or closet space, either provided by the ACLF or by the resident if the resident prefers. All furniture provided by the resident must meet NFPA standards;

(e) Maintain all residents' clothing in good repair and ensure that it is suitable for the use of elderly persons;

(f) Maintain the building and its heating, cooling, plumbing and electrical systems in good repair and in clean condition at all times; and

(g) Maintain temperatures in resident sleeping units and common areas at not less than 65°F.and no more than 85°F.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, and 68-11-213.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed April 11, 2003; effective June 25, 2003. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009.*

1200-08-25-.11 INFECTIOUS AND HAZARDOUS WASTE.

(1) An ACLF must develop, maintain and implement written policies and procedures for the definition and handling of its infectious waste. These policies and procedures must comply with the standards of this rule.

(2) The following waste shall be considered to be infectious waste:

(a) Waste contaminated by residents who are isolated due to communicable disease, as provided in the U.S. Centers for Disease Control "Guidelines for Isolation Precautions in Hospitals";

(b) Cultures and stocks of infectious agents including specimen cultures collected from medical and pathological laboratories, cultures and stocks of infectious agents from research and industrial laboratories, wastes from the production of biologicals, discarded live and attenuated vaccines, and culture dishes and devices used to transfer, inoculate, and mix cultures;

(c) Waste human blood and blood products such as serum, plasma, and other blood components;

(d) Pathological waste, such as tissues, organs, body parts, and body fluids that are removed during surgery and autopsy;

1200-08-34-.05 ADMISSIONS, DISCHARGES, AND TRANSFERS.

(1) Consumers shall be accepted to receive professional support services on the basis of a reasonable expectation that the consumer's nursing and therapy needs can be met adequately by the agency.

(2) Professional support services shall be provided as prescribed by the attending physician. The plan for providing professional support services and the expected outcomes shall be incorporated into the consumer's plan of care or individual support plan.

(3) The agency staff shall determine if the consumer's needs can be met by the agency's services and capabilities.

(4) Every person admitted for professional support services by any agency covered by these rules shall be provided services as prescribed by the consumer's physician, as defined in this chapter, who holds a license in good standing. The name of the consumer's attending physician shall be recorded in the consumer's medical record.

(5) The agency staff shall obtain the consumer's or his/her designee's written consent for professional support services.

(6) The signed consent form shall be included with the consumer's individual clinical record.

(7) A diagnosis must be entered in the admission records of the agency for every person admitted for care or treatment.

(8) No medication or treatment shall be provided to any consumer of an agency except on the order of a physician lawfully authorized to give such an order.

(9) A medical record shall be developed and maintained for each consumer admitted.

~~(10) The agency's discharge planning process, including discharge policies and procedures, must be in writing and follow the guidelines established in the written agreement between the agency and the Division of Mental Retardation Services (DMRS). If the agency determines that they are no longer willing or able to provide services, they must comply with the following:~~

(10) The agency's discharge planning process, including discharge policies and procedures, must be in writing and follow the guidelines established in the written agreement between the agency and the Department of Intellectual and Developmental Disabilities (DIDD). If the agency determines that they are no longer willing or able to provide services, they must comply with the following:

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~~(a) Prior to discontinuation of authorized services, the agency shall obtain approval from the DMRS;~~

(a) Prior to discontinuation of authorized services, the agency shall obtain approval from the DIDD;

~~(b) The agency shall notify the consumer, their conservator or guardian, the support coordinator, and DMRS no less than sixty (60) days prior to the planned discharge;~~

(b) The agency shall notify the consumer, their conservator or guardian, the support coordinator, and DIDD no less than sixty (60) days prior to the planned discharge;

(Rule 1200-08-34-.05, continued)

(c) If the consumer or his/her representative request an appeal in accordance with T.C.A. § 33-2-601, et seq., the discharge will not occur prior to the final agency decision and resolution of the administrative appeal unless ordered by a court and approved by the state;

(d) The agency shall continue to provide services until the consumer is provided with other services that are of acceptable and appropriate quality in order to maintain continuity of care; and

(e) If the consumer or his/her representative request to be discharged from the agency, the agency will follow the steps as outlined above and provide transfer documentation to new provider, if requested, in order to maintain continuity of care and facilitate transfer.

(11) The agency shall ensure that no person on the grounds of race, color, national origin or handicap, will be excluded from participation in, be denied benefits of, or otherwise subjected to discrimination in the provision of any care or service of the agency. The agency shall protect the civil rights of residents under the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, and 68-11-209.* ***Administrative History:*** *Original rule filed January 24, 2003; effective April 9, 2003.*

1200-08-34-.06 BASIC AGENCY FUNCTIONS.

(1) All personnel providing professional support services shall assure that their efforts effectively complement other services provided to the consumer, are functionally integrated into the individual daily routine and support the outcome outlined in the individual support plan. A written report of progress shall be provided to the consumer's support coordinator/case manager monthly. A written summary report for each consumer shall be sent to the attending physician at least annually.

(2) Plan of Care.

(a) The written plan of care, developed in consultation with the agency staff, shall cover all pertinent diagnoses, including mental status, types of services and equipment required, frequency of services, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. If a physician refers a consumer under a plan of care which cannot be completed until after an evaluation visit, the physician shall be consulted to approve additions or modifications to the original plan. Orders for professional support services shall include the specific treatment or modalities to be used and their amount, frequency and duration. The therapist and other agency personnel shall participate in developing the plan of care.

(b) The plan(s) of care for acute or episodic illness shall be reviewed by the attending physician and agency personnel involved in the consumer's care as often as the severity of the consumer's condition requires, but at least annually. Plans of care resulting from Comprehensive Nursing Assessment will be reviewed in accordance with the physical status review schedule. Evidence of review by the physician must include the physician's signature and date of the review on the plan of care. A facsimile of the physician's signature is acceptable. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care.