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Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing. TCA Section 4-5-205

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Revision Type (check all that apply):

X Amendment
___ New
___ Repeal

Rule(s) Revised (**ALL** chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables. Please enter only **ONE** Rule Number/RuleTitle per row)

Chapter Number	**Chapter Title**
1200-08-25	Standards for Assisted-Care Living Facilities
Rule Number	**Rule Title**
1200-08-25-.01	Purpose
1200-08-25-.02	Definitions
1200-08-25-.03	Licensing Requirements
1200-08-25-.04	Fees
1200-08-25-.05	Regulatory Standards
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(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to http://state.tn.us/sos/rules/1360/1360.htm)

Substance of Proposed Rules

Chapter 1200-08-25
Standard for Assisted-Care Living Facilities

Amendments

Chapter 1200-08-25, Standards for Assisted-Care Living Facilities, is amended by deleting it in its entirety, and substituting instead the following so that as amended, the new chapter shall read:

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. §§ 68-11-201, 68-11-209 and 68-11-213.

1200-08-25-.02 Definitions.

(1) "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.

(2) "Administering medication" means the direct application of a single dose of a medication to the body of a resident by injection, inhalation, ingestion, topical application or by any other means.

(3) "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.

(4) "Adult" means a person 18 years of age or older.

(5) "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.

(6) "Assisted-care living facility (ACLF)" means a building, establishment, complex or distinct part thereof that accepts primarily aged persons for domiciliary care and services.

(7) "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.

(8) "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.

(9) "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.

(10) "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.

(11) "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.

(12) "Do Not Resuscitate (DNR) Order" means a written order entered by the resident's treating physician in the resident's medical record which states that in the event the resident suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should not be attempted. The order may contain limiting language to allow only certain types of cardiopulmonary resuscitation to the exclusion of other types of cardiopulmonary resuscitation.

(13) "Emergency" means any situation or condition which presents an imminent danger of death or serious physical or mental harm to residents.

(14) "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).

(15) "Health care decision" means an individual's consent, refusal of consent or withdrawal of consent to health care.

(16) "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).

(17) "Infectious waste" means solid or liquid wastes which contain pathogens with sufficient virulence and quantity such that exposure could result in an infectious disease.

(18) "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.

(19) "Licensee" means the person, association, partnership, corporation, company or public agency to which the license is issued.

(20) "Life threatening or serious injury" means an injury requiring the resident to undergo significant diagnostic or treatment measures.

(21) "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.

(22) "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.

(23) "NFPA" means the National Fire Protection Association.

(24) "Patient abuse" means 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.

(25) "Person" means an individual, association, estate, trust, corporation, partnership, joint venture, government, governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

(26) "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.

(27) "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.

(28) "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.

(29) "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.

(30) "Responsible attendant" means the individual person designated by the licensee to provide personal services to the residents.

(31) "Secured unit" means a distinct part of an ACLF where the residents are intentionally denied egress by any means.

(32) "Self-administration of medication" means assistance in reading labels, opening dosage packaging, reminding residents of their medication, or observing the resident while taking medication in accordance with the plan of care.

(33) "Supervising health care provider" means the health care provider who has undertaken primary responsibility for an individual's health care.

(34) "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.

(35) "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.

(36) "Universal Do Not Resuscitate Order" means a written order that applies regardless of the treatment setting and that is signed by the patient's physician which states that in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should not be attempted.

(37) "Unusual event" means an unexpected occurrence or accident that is unrelated to the natural course of the resident's illness or underlying condition that results in death, life threatening or serious injury to a resident. An unusual event also includes an incident resulting in the abuse of a resident.

Authority: T.C.A. §§ 68-11-201 and 68-11-209.

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

(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 expire annually on June 30 and must be renewed by that date.

(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) Should the licensee fail to renew its license prior to the expiration date, yet within sixty (60) days after the expiration date, then the licensee shall pay a late renewal penalty fee of one hundred dollars ($100.00) per month for each month or fraction of a month that renewal is late.

(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;

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

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;

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

   (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. § 68-11-209 and Chapter 846 of the Public Acts of 2008, § 1.

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.

Authority: T.C.A. §§ 68-11-209 and 68-11-216.

1200-08-25-.05 Regulatory Standards.

(1) A Department of Health representative shall make an unannounced inspection of every ACLF holding a license granted by the Board for its compliance with applicable state law and regulations within fifteen (15) months following the date of its last inspection, and as necessary, to protect the public's health, safety and welfare. An ACLF must cooperate during Department of Health conducted inspections, including allowing entry at any hour and providing all required records.

(2) Plan of Correction. When Department of Health inspectors find that an ACLF has committed a violation of this chapter, the Department of Health, as the Board's representative, will issue a statement of deficiencies to the ACLF. Within ten (10) days of receipt of the statement of deficiencies, the ACLF must return a plan of correction including the following:

(a) How the deficiency will be corrected;

(b) The date upon which each deficiency will be corrected;

(c) What measures or systemic changes will be put in place to ensure that the deficient practice does not recur; and

(d) How the corrective action will be monitored to ensure that the deficient practice does not recur.

(3) Either failure to submit a plan of correction in a timely manner or a finding by the Department of Health that the plan of correction is unacceptable may subject the ACLF's license to disciplinary action.

(4) Upon a finding by the Board that an ACLF has violated any provision of the Health Facilities and Resources Act, Part 2—Regulation of Health and Related Facilities (T.C.A. §§ 68-11-201, *et seq.*) or the rules promulgated pursuant thereto, action may be taken, upon proper notice to the licensee, to impose a civil penalty, deny, suspend, or revoke its license.

(5) Civil Penalties. The Board may, in a lawful proceeding respecting licensing (as defined in the Uniform Administrative Procedures Act), in addition to or in lieu of other lawful disciplinary action, assess civil penalties for violations of statutes, rules or orders enforceable by the Board in accordance with the following schedule:

Violation	Penalty
T.C.A. § 68-11-201(4)(B) (Provision of Room and Board and Non-Medical Living Assistance Services)	$0-$1000
T.C.A. § 68-11-201(4)(C) (Provision of Medical and other Professional Services; Medicare Services; Oversight of Medical Services; Plan of Care & Assessment; Personal and Medical Records; and, Fire Safety)	$0-$1000
T.C.A. § 68-11-213(i)(2) (Admission or Retention of Inappropriately Placed Resident.) Each resident shall constitute a separate violation.)	$0-$3000
T.C.A. § Section 68-11-213(i)(1) (Operating ACLF without Required License. Each day of operation shall constitute a separate violation.)	$0-$5000

In determining the amount of any civil penalty to be assessed pursuant to this rule the Board may consider such factors as the following:

(a) Willfulness of the violation;

(b) Repetitiveness of the violation;

(c) Magnitude of the risk of harm caused by the violation.

(6) Each violation of any statute, rule or order enforceable by the Board shall constitute a separate and distinct offense and may render the ACLF committing the offense subject to a separate penalty for each violation.

(7) A licensee may appeal any disciplinary action taken against it in accordance with the Uniform Administrative Procedures Act, Tennessee Code Annotated § 4-5-101, *et seq.*

(8) 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 1360-4-1-.18 regarding petitions for reconsiderations and stays in that case.

Authority: T.C.A. §§ 68-11-209 and 68-11-213(i).

1200-08-25-.06 Administration.

(1) Each ACLF shall meet the following staffing and procedural standards:

(a) Staffing Requirements:

1. The licensee must designate in writing a capable and responsible person to act on administrative matters and to exercise all the powers and responsibilities of the licensee as set forth in this chapter in the absence of the licensee.

2. If the licensee is a natural person, the licensee shall be at least eighteen (18) years of age, of reputable and responsible character, able to comply with these rules, and must maintain financial resources and income sufficient to provide for the needs of the residents, including their room, board, and personal services.

3. An ACLF shall have an identified responsible attendant who is alert and awake at all times and a sufficient number of employees to meet the residents' needs, including medical services as prescribed. The responsible attendant and direct care staff must be at least eighteen (18) years of age and capable of complying with statutes and rules governing ACLFs.

4. An ACLF shall have a licensed nurse available as needed.

5. An ACLF shall employ a qualified dietitian, full time, part-time, or on a consultant basis.

6. An ACLF may not employ an individual listed on the Abuse Registry maintained by the Department of Health.

(b) Policies and Procedures:

1. An ACLF shall have a written statement of policies and procedures outlining the facility's responsibilities to its residents, any obligation residents have to the facility, and methods by which residents may file grievances and complaints.

2. An ACLF shall develop and implement an effective facility-wide performance improvement plan that addresses plans for improvement for self-identified deficiencies and documents the outcome of remedial action.

3. An ACLF shall develop a written policy, plan or procedure concerning a subject and adhere to its provisions whenever required to do so by these rules. A licensee that violates its own policy established as required by these rules and regulations also violates the rules and regulations establishing the requirement.

4. An ACLF shall develop a written policy and procedure governing smoking practices of residents.

(i) Residents of the facility are exempt from the smoking prohibition that otherwise applies to the ACLF.

(ii) Smoke from permissible smoking areas shall not infiltrate into areas where smoking is prohibited.

5. An ACLF shall develop a concise statement of its charity care policies and shall post such statement in a place accessible to the public.

(c) An ACLF shall keep a written up-to-date log of all residents that can be produced in the event of an emergency.

(d) An ACLF shall allow pets in the ACLF only when they are not a nuisance and do not pose a health hazard. Plans for pet management must be approved by the Department.

(e) No person associated with the licensee or ACLF shall act as a court-appointed guardian, trustee, or conservator for any resident of the ACLF or any of such resident's property or funds, except as provided by rule 1200-08-25-.14(1)(i).

(f) An ACLF shall not 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 ACLF shall neither retaliate nor discriminate, because any person lawfully provides information to these authorities, cooperates with them, or is subpoenaed to testify at a hearing involving them.

(2) In the event a resident dies at an ACLF, a registered nurse may make the actual determination and pronouncement of death under the following circumstances.

(a) 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 and with the deceased at the place of death;

(b) The nurse is licensed by the Tennessee Board of Nursing; and

(c) The nurse is employed by the ACLF in which the deceased resided.

(3) In the event that resident, receiving services of a Medicare certified hospice program licensed by the state, dies at an ACLF, a registered nurse may make the actual determination and pronouncement of death under the following circumstances:

(a) The deceased was suffering from a terminal illness;

(b) 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 and with the deceased at the place of death;

(c) The nurse is licensed by the Tennessee Board of Nursing; and

(d) The nurse is employed by the hospice program from which the deceased had been receiving hospice services.

(4) An ACLF shall post the following at the main public entrance:

(a) 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 of Adult Protective Services. The statement shall include the statewide toll-free number for the Division and the telephone number for the local district attorney's office. The posting shall be on a sign no smaller than eleven inches by seventeen inches. (This same information shall be provided to each resident in writing upon admission to any facility);

(b) A statement that any person, regardless of age, who may be the victim of domestic violence may call the nationwide domestic violence hotline for immediate assistance, with that number printed in boldface type, and posted on a sign no smaller than eight and one-half inches (8½") in width and eleven inches (11") in height;

(c) A statement regarding whether it has liability insurance, the identity of their primary insurance carrier, and if self-insured, the corporate entity responsible for payment of any claims. It shall be posted on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height; and

(d) "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.

(e) A statement that any person who has experienced a problem with a specific licensed ACLF may file a complaint with the Division of Health Care Facilities. The posting shall include the statewide toll-free telephone number for the Division's centralized complaint intake unit.

(5) Infection Control

(a) An ACLF shall ensure that neither a resident nor an employee of the ACLF with a reportable communicable disease shall reside or work in the ACLF unless the ACLF has a written protocol approved by the Board's administrative office.

(b) An ACLF 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. A statement that the requirements to complete vaccinations or declination statements shall be suspended by the administrator in the event of a vaccine shortage.

(c) An ACLF and its employees shall adopt and utilize standard precautions in accordance with guidelines established by the Centers for Disease Control and Prevention (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 resident contact if hands are not visibly soiled;

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

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

4. Health care worker education programs which may include:

   (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, 68-11-209, 68-11-254, 68-11-268, and 71-6-121.

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) The administration of self-administered medications excluding intravenous injections that may only be administered to:

1. Existing residents who receive them on an intermittent basis; and

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.

(6) An ACLF shall dispose of medications as follows:

(a) Upon discharge or death of a resident, unused medications shall be released to the resident, family member, or legal representative unless specifically prohibited by the attending physician or other authorized healthcare provider.

(b) Any scheduled drug that is misbranded, expired, deteriorated, or not kept under proper conditions or in containers with illegible or missing labels shall be returned to the pharmacy within five (5) working days after discovery for proper disposition by a licensed pharmacist.

(c) Any non-scheduled drug or device that is misbranded, expired, deteriorated, or not kept under proper conditions or in containers with illegible or missing labels shall be properly disposed of at the ACLF in the presence of another licensed or certified professional.

(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

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.

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. §§ 68-11-201, 68-11-206, and 68-11-209.

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:

(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;

(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.

(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.

(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;

(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. §§ 68-11-201(5), 68-11-209, 68-11-211, 68-11-263 and 68-11-266.

Rule 1200-08-25-.09 Building Standards.

(1) An ACLF shall construct, arrange, and maintain the condition of the physical plant and the overall ACLF living facility environment in such a manner that the safety and well-being of residents 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 new facilities shall conform to the 2006 edition of the International Building Code, the 2006 edition of the National Fire Protection Code (NFPA), the 2005 edition of National Electrical Code, and the 1999 edition of the U.S Public Health Service Food Code as adopted by the Board for Licensing Health Care Facilities. The requirements of the Americans with Disabilities Act (A.D.A.), as revised in 2004, and the 1999 edition of North Carolina Handicap Accessibility Codes with 2004 amendments apply to all new and existing facilities. Where there are conflicts between requirements in local codes, the above listed codes and 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) The licensed contractor shall perform all new construction and renovations to assisted care living facilities, other than minor alterations not affecting fire and life safety or functional issues, in accordance with the specific requirements of these regulations governing new construction in assisted care living facilities, including the submission of phased construction plans and the final drawings and the specifications to each.

(5) No new ACLF shall be constructed, nor shall major alterations be made to an existing ACLF without prior approval of the department, and unless in accordance with plans and specifications approved in advance by the department. Before any new ACLF is licensed or before any alteration or expansion of a licensed ACLF can be approved, the applicant must furnish two (2) complete sets of plans and specifications to the department, together with fees and other information as required. Plans and specifications for new construction and major renovations, other than minor alterations not affecting fire and life safety or functional issues, shall be prepared by or under the direction of a licensed architect and/or a licensed engineer and in accordance with the rules of the Board of Architectural and Engineering Examiners.

(6) Final working drawings and specifications shall be accurately dimensioned and include all necessary explanatory notes, schedules and legends. The working drawings and specifications shall be complete and adequate for contract purposes.

(7) Detailed plans shall be drawn to a scale of at least one-eighth inch equals one foot (1/8" = 1'), and shall show the general arrangement of the building, the intended purpose and the fixed equipment in each room, with such additional information as the department may require. An architect or engineer licensed to practice in the State of Tennessee shall prepare the plans the department requires.

(a) The project architect or engineer shall forward two (2) sets of plans to the appropriate section of the department for review. After receipt of approval of phased construction plans, the owner may proceed with site grading and foundation work prior to receipt of approval of final plans and specifications with the owner's understanding that such work is at the owner's own risk and without assurance that final approval of final plans and specifications shall be granted. The project architect or engineer shall submit final plans and specifications for review and approval. The department must grant final approval before the project proceeds beyond foundation work.

(b) Review of plans does not eliminate responsibility of owner and/or architect to comply with all rules and regulations.

(8) Specifications shall supplement all drawings. They shall describe the characteristics of all materials, products and devices, unless fully described and indicated on the drawings. Specification copies should be bound in an 8½ x 11 inch folder.

(9) Drawings and specifications shall be prepared for each of the following branches of work: Architectural, Structural, Mechanical, Electrical and Sprinkler.

(10) Architectural drawings shall include:

(a) Plot plan(s) showing property lines, finish grade, location of existing and proposed structures, roadways, walks, utilities and parking areas;

(b) Floor plan(s) showing scale drawings of typical and special rooms, indicating all fixed and movable equipment and major items of furniture;

(c) Separate life safety plans showing the compartment(s), all means of egress and exit markings, exits and travel distances, dimensions of compartments and calculation and tabulation of exit units. All fire and smoke walls must be identified;

(d) The elevation of each facade;

(e) The typical sections throughout the building;

(f) The schedule of finishes;

(g) The schedule of doors and windows;

(h) Roof plans;

(i) Details and dimensions of elevator shaft(s), car platform(s), doors, pit(s), equipment in the machine room, and the rates of car travel must be indicated for elevators; and

(j) Code analysis.

(11) Structural drawings shall include:

(a) Plans of foundations, floors, roofs and intermediate levels which show a complete design with sizes, sections and the relative location of the various members;

(b) Schedules of beams, girders and columns; and

(c) Design live load values for wind, roof, floor, stairs, guard, handrails, and seismic.

(12) Mechanical drawings shall include:

(a) Specifications which show the complete heating, ventilating, fire protection, medical gas systems and air conditioning systems;

(b) Water supply, sewerage and HVAC piping systems;

(c) Pressure relationships shall be shown on all floor plans;

(d) Heating, ventilating, HVAC piping, medical gas systems and air conditioning systems with all related piping and auxiliaries to provide a satisfactory installation;

(e) Water supply, sewage and drainage with all lines, risers, catch basins, manholes and cleanouts clearly indicated as to location, size, capacities, etc., and location and dimensions of septic tank and disposal field; and

(f) Color coding to show clearly supply, return and exhaust systems.

(13) Electrical drawings shall include:

(a) A Seal, certifying that all electrical work and equipment is in compliance with all applicable codes and that all materials are currently listed by recognized testing laboratories;

(b) All electrical wiring, outlets, riser diagrams, switches, special electrical connections, electrical service entrance with service switches, service feeders and characteristics of the light and power current, and transformers when located within the building;

(c) The electrical system shall comply with applicable codes, and shall include:

1. The fire alarm system; and

2. The emergency power system including automatic services as defined by the codes.

(d) Color coding to show all items on emergency power.

(14) Sprinkler drawings shall include:

(a) Shop drawings, hydraulic calculations, and manufacturer cut sheets;

(b) Site plan showing elevation of fire hydrant to building, test hydrant, and flow data (Data from within a 12 month period); and

(c) Show "Point of Service" where water is used exclusively for fire protection purposes.

(15) The licensed contractor shall not install a system of water supply, plumbing, sewage, garbage or refuse disposal nor materially alter or extend any existing system until the architect or engineer submits complete plans and specifications for the installation, alteration or extension to the department demonstrating that all applicable codes have been met and the department has granted necessary approval.

(a) Before the ACLF is used, Tennessee Department of Environment and Conservation shall approve the water supply system.

(b) Sewage shall be discharged into a municipal system or approved package system where available; otherwise, the sewage shall be treated and disposed of in a manner of operation approved by the Department of Environment and Conservation and shall comply with existing codes, ordinances and regulations which are enforced by cities, counties or other areas of local political jurisdiction.

(c) Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at shower, bathing and hand washing facilities shall be between 105°F and 115°F.

(16) The licensed contractor shall ensure through the submission of plans and specifications that in each ACLF:

(a) A negative air pressure shall be maintained in the soiled utility area, toilet room, janitor's closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms;

(b) A minimum of eighty (80) square feet of bedroom space must be provided each resident. No bedroom shall have more than two (2) beds. Privacy screens or curtains must be provided and used when requested by the resident;

(c) Living room and dining areas capable of accommodating all residents shall be provided, with a minimum of fifteen (15) square feet per resident per dining area; and

(d) Each toilet, lavatory, bath or shower shall serve no more than six (6) persons. Grab bars and non-slip surfaces shall be installed at tubs and showers.

(17) With the submission of plans the facility shall specify the evacuation capabilities of the residents as defined in the National Fire Protection Code (NFPA). This declaration will determine the design and construction requirements of the facility.

(18) The department shall acknowledge that it has reviewed plans and specifications in writing with copies sent to the project architect, the project engineer and the owner as well as the manager or other executive of the institution. The department may modify the distribution of such review at its discretion.

(19) In the event submitted materials do not appear to satisfactorily comply with 1200-08-25-.09 (2), the department shall furnish a letter to the party submitting the plans which shall list the particular items in question and request further explanation and/or confirmation of necessary modifications.

(20) The licensed contractor shall execute all construction in accordance with the approved plans and specifications.

(21) If construction begins within one hundred eighty (180) days of the date of department approval, the department's written notification of satisfactory review constitutes compliance with 1200-08-25-.09(20). This approval shall in no way permit and/or authorize any omission or deviation from the requirements of any restrictions, laws, regulations, ordinances, codes or rules of any responsible agency.

(22) Prior to final inspection, the licensed contractor shall submit a CD Rom disc, in TIF or DMG format, of the final approved plans including all shop drawings, sprinkler, calculations, hood and duct, addenda, specifications, etc., to the department.

(23) The department requires the following alarms that shall be monitored twenty-four (24) hours per day:

(a) Fire alarms; and

(b) Generators (if applicable).

(24) 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. §§ 68-11-202, 68-11-209 and 68-11-261.

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;

(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.

(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.

(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:

(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. §§ 68-11-202 and 68-11-209.

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;

(e) All discarded sharps (e.g., hypodermic needles, syringes, pasteur pipettes, broken glass, scalpel blades) used in resident care or which have come into contact with infectious agents during use in medical, research, or industrial laboratories; and

(f) Other waste determined to be infectious by the ACLF in its written policy.

(3) Infectious and hazardous waste must be segregated from other waste at the point of generation (i.e., the point at which the material becomes a waste) within the ACLF.

(4) Waste must be packaged in a manner that will protect waste handlers and the public from possible injury and disease that may result from exposure to the waste. Such packaging must provide for containment of the waste from the point of generation up to the point of proper treatment or disposal. Packaging must be selected and utilized for the type of waste the package will contain, how the waste will be treated and disposed, and how it will be handled and transported, prior to treatment and disposal.

(a) Contaminated sharps must be directly placed in leakproof, rigid, and puncture-resistant containers which must then be tightly sealed.

(b) Whether disposable or reusable, all containers, bags, and boxes used for containment and disposal of infectious waste must be conspicuously identified. Packages containing infectious waste which pose additional hazards (e.g., chemical, radiological) must also be conspicuously identified to clearly indicate those additional hazards.

(c) Reusable containers for infectious waste must be thoroughly sanitized each time they are emptied, unless the surfaces of the containers have been completely protected from contamination by disposable liners or other devices removed with the waste.

(d) Opaque packaging must be used for pathological waste.

(5) After packaging, waste must be handled and transported by methods ensuring containment and preservation of the integrity of the packaging, including the use of secondary containment where necessary. Plastic bags of infectious waste must be transported by hand.

(6) Waste must be stored in a manner which preserves the integrity of the packaging, inhibits rapid microbial growth and putrefaction, and minimizes the potential of exposure or access by unknowing persons.

(a) Waste must be stored in a manner and location which affords protection from animals, precipitation, wind, and direct sunlight, does not present a safety hazard, does not provide a breeding place or food source for insects or rodents, and does not create a nuisance.

(b) Pathological waste must be promptly treated, disposed of, or placed into refrigerated storage.

(7) In the event of spills, ruptured packaging, or other incidents where there is a loss of containment of waste, the ACLF must ensure that proper actions are immediately taken to:

(a) Isolate the area from the public and all except essential personnel;

(b) To the extent practicable, repackage all spilled waste and contaminated debris in accordance with the requirements of paragraph 6 of this rule;

(c) Sanitize all contaminated equipment and surfaces according to written policies and procedures which specify how this will be done appropriately; and

(d) Complete an incident report and maintain a copy on file.

(8) Except as provided otherwise in this rule a facility must treat or dispose of infectious waste by one or more of the methods specified in this paragraph.

(a) An ACLF may treat infectious waste in an on-site sterilization or disinfection device, or in an incinerator or a steam sterilizer, which has been designed, constructed, operated and maintained so that infectious waste treated in such a device is rendered non-infectious and is, if applicable, authorized for that purpose pursuant to current rules of the Department of Environment and Conservation. A valid permit or other written evidence of having complied with the Tennessee Air Pollution Control Regulations shall be available for review, if required. Each sterilizing or disinfection cycle must contain appropriate indicators to assure that conditions were met for proper sterilization or disinfection of materials included in the cycle, and appropriate records kept. Proper operation of such devices must be verified at least monthly, and records of the monthly verifications shall be available for review. Waste that contains toxic chemicals that would be volatilized by steam must not be treated in steam sterilizers. Infectious waste that has been rendered to carbonized or mineralized ash shall be deemed non-infectious. Unless otherwise hazardous and subject to the hazardous waste management

requirements of the current rules of the Department of Environment and Conservation, such ash shall be disposable as a (non-hazardous) solid waste under current rules of the Department of Environment and Conservation.

(b) An ACLF may discharge liquid or semi-liquid infectious waste to the collection sewerage system of a wastewater treatment facility which is subject to a permit pursuant to T.C.A. §§ 69-3-101, et seq., provided that such discharge is in accordance with any applicable terms of that permit and/or any applicable municipal sewer use requirements.

(c) Any health care facility accepting waste from another state must promptly notify the Department of Environment and Conservation, county, and city public health agencies, and must strictly comply with all applicable local, state and federal regulations.

(9) An ACLF may have waste transported off-site for storage, treatment, or disposal. Such arrangements must be detailed in a written contract, available for review. If such off-site location is located within Tennessee, the ACLF must ensure that it has all necessary State and local approvals, and such approvals shall be available for review. If the off-site location is within another state, the ACLF must notify in writing all public health agencies with jurisdiction that the location is being used for management of the ACLF's waste. Waste shipped off-site must be packaged in accordance with applicable federal and state requirements. Waste transported to a sanitary landfill in this state must meet the requirements of current rules of the Department of Environment and Conservation.

(10) Human anatomical remains which are transferred to a mortician for cremation or burial shall be exempt from the requirements of this rule.

(11) All garbage, trash and other non-infectious waste 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, constructed of easily-cleanable material, and shall be kept on elevated platforms.

Authority: T.C.A. § 68-11-209.

1200-08-25-.12 Resident Records

(1) An ACLF shall develop and maintain an organized record for each resident and ensure that all entries shall be written legibly in ink, typed, or kept electronically, and signed, and dated.

(2) Personal record. An ACLF shall ensure that the resident's personal record includes at a minimum the following:

(a) Name, Social Security Number, veteran status and number, marital status, age, sex, any health insurance provider and number, including Medicare and/or Medicaid number, and photograph of the resident;

(b) Name, address and telephone number of next of kin, legal representative (if applicable), and any other person identified by the resident to contact on the resident's behalf;

(c) Name and address of the resident's preferred physician, hospital, pharmacist and nursing home, and any other instructions from the resident to be followed in case of emergency;

(d) Record of all monies and other valuables entrusted to the ACLF for safekeeping, with appropriate updates;

(e) Date of admission, transfer, discharge and any new forwarding address;

(f) A copy of the admission agreement that is signed and dated by the resident;

(g) A copy of any advance directives, DNR Order, Durable Power of Attorney, or living will, when applicable, and made available upon request; and

(h) A record that the resident has received a copy of the ACLF's resident's rights and procedures policy.

(3) Medical record. An ACLF shall ensure that its employees develop and maintain a medical record for each resident who requires health care services at the ACLF regardless of whether such services are rendered by the ACLF or by arrangement with an outside source, which shall include at a minimum:

(a) Medical history;

(b) Consultation by physicians or other authorized healthcare providers;

(c) Orders and recommendations for all medication, medical/and other care, services, procedures, and diet from physicians or other authorized healthcare providers, which shall be completed prior to, or at the time of admission, and subsequently, as warranted. Verbal orders received shall include the time of receipt of the order, description of the order, and identification of the individual receiving the order;

(d) Care/services provided, including identification of providing party;

(e) Medications administered and procedures followed if an error is made;

(f) Special procedures and preventive measures performed;

(g) Notes, including, but not limited to, observation notes, progress notes, and nursing notes;

(h) Listing of current vaccinations,

(i) Time and circumstances of discharge or transfer, including condition at discharge or transfer, or death;

(j) Provisions of routine and emergency medical care, to include the name and telephone number of the resident's physician, plan for payment, and plan for securing medications;

(k) Special information, e.g., do-not resuscitate orders, allergies, etc.; and

(l) Copy of quarterly Alzheimer's review, if medically indicated.

(4) An ACLF shall complete a written assessment of the resident to be conducted by a direct care staff member within a time-period determined by the ACLF, but no later than seventy-two (72) hours after admission.

(5) Plan of care.

(a) An ACLF shall develop a plan of care for each resident admitted to the ACLF with input and participation from the resident or the resident's legal representative, treating physician, or other licensed health care professionals or entity delivering patient services within five (5) days of admission. The plan of care shall be reviewed and/or revised as changes in resident needs occur, but not less than semi-annually by the above-appropriate individuals.

(b) The plan of care shall describe:

1. The needs of the resident, including the activities of daily living and medical services for which the resident requires assistance, i.e., what assistance/care, how much, who will provide the assistance/care, how often, and when;

2. Requirements and arrangements for visits by or to physicians or other authorized health providers;

3. Advance care directive, healthcare power-of-attorney; as applicable;

4. Recreational and social activities which are suitable, desirable, and important to the well-being of the resident; and

5. Dietary needs.

(6) Personal information shall be confidential and shall not be disclosed, except to the resident, the department and others with written authorization from the resident. Records shall be retained for three (3) years after the resident has been transferred or discharged.

(7) An ACLF shall retain legible copies of the following records and reports for thirty-six (36) months following their issuance. The reports shall be maintained in a single file, and shall be made available for inspection during normal business hours to any resident who requests to view them. Each resident and each person assuming any financial responsibility for a resident must be fully informed, before admission, of the existence of the reports in the ACLF and given the opportunity to inspect the file before entering into any monetary agreement with the ACLF.

(a) Local fire safety inspections.

(b) Local building code inspections, if any.

(c) Department licensure and fire safety inspections and surveys.

(d) Orders of the Commissioner or Board, if any.

(e) Maintenance records of all safety equipment.

Authority: T.C.A. §§ 68-11-201 AND 68-11-209.

1200-08-25-.13 Reports.

(1) Unusual events shall be reported to the Department of Health by the ACLF in accordance with T.C.A. §§ 68-11-211, et seq.

(2) An ACLF shall file the Joint Annual Report of Assisted Care Living Facilities with the department. The forms shall be furnished and mailed to each ACLF by the department each year and the forms must be completed and returned to the department as required.

Authority: T.C.A. §§ 68-11-209 and 68-11-211.

1200-08-25-.14 Resident Rights.

(1) An ACLF shall ensure at least the following rights for each resident:

(a) To be afforded privacy in treatment and personal care;

(b) To be free from mental and physical abuse. Should this right be violated, the ACLF shall notify the department and the Tennessee Department of Human Services, Adult Protective Services at 1-888-277-8366;

(c) To refuse treatment. An ACLF must inform the resident of the consequences of that decision. The ACLF must report the resident's refusal and its reason to the resident's treating physician and it must document such in the resident's record;

(d) To have his or her file kept confidential and private. An ACLF shall obtain the resident's written consent prior to release of information except as otherwise authorized by law;

(e) To be fully informed of the Resident's Rights, of any policies and procedures governing resident conduct, of any services available in the ACLF, and of the schedule of all fees for any and all services;

(f) To participate in drawing up the terms of the admission agreement, including, but not limited to, providing for resident's preferences for physician care, hospitalization, nursing home care, acquisition of medication, emergency plans and funeral arrangements;

(g) To be given thirty (30) days written notice prior to transfer or discharge, except when any physician orders the transfer because the resident requires a higher level of care;

(h) To voice grievances and recommend changes in policies and services of the ACLF without restraint, interference, coercion, discrimination or reprisal. An ACLF shall inform the resident of procedures to voice grievances and for registering complaints confidentially;

(i) To manage his or her personal financial affairs, including the right to keep and spend his or her own money. If the resident requests assistance from the ACLF in managing his or her personal financial affairs, the request must be in writing and the resident may terminate it at any time. The ACLF must separate such monies from the ACLF's operating funds and all other deposits or expenditures, submit a written accounting to the resident at least quarterly, and immediately return the balance upon transfer or discharge. The ACLF shall maintain a current copy of this report in the resident's file;

(j) To be treated with consideration, respect and full recognition of his or her dignity and individuality;

(k) To be accorded privacy for sleeping and for storage space for personal belongings;

(l) To have free access to day rooms, dining and other group living or common areas at reasonable hours and to come and go from the ACLF, unless such access infringes upon the rights of other residents;

(m) To wear his or her own clothes, to keep and use his or her own toilet articles and personal possessions;

(n) To send and receive unopened mail;

(o) To associate and communicate privately with persons of his or her choice, including receiving visitors at reasonable hours;

(p) To participate, or to refuse to participate, in community activities, including cultural, educational, religious, community service, vocational and recreational activities;

(q) To not be required to perform services for the ACLF. The resident and licensee may mutually agree, in writing, that the resident may perform certain activities or services as part of the fee for his or her stay; and

(r) To execute, modify, or rescind a Living Will, Do-Not-Resuscitate Order or advance directive.

Authority: T.C.A. § 68-11-209.

1200-08-25-.15 Policies and Procedures for Health Care Decision-Making.

(1) Pursuant to this rule, each ACLF shall maintain and establish policies and procedures governing the designation of a health care decision-maker for making health care decisions for a resident who is incompetent or who lacks capacity,

including but not limited to allowing the withholding of CPR measures from individual residents. An adult or emancipated minor may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.

(2) An adult or emancipated minor may execute an advance directive for health care. The advance directive may authorize an agent to make any health care decision the resident could have made while having capacity, or it may limit the power of the agent, and it may include individual instructions. An advance directive that makes no limitation on the agent's authority shall authorize the agent to make any health care decision the resident could have made while having capacity.

(3) The advance directive shall be in writing, signed by the resident, and shall either be notarized or witnessed by two (2) witnesses. Both witnesses shall be competent adults, and neither of them may be the agent. At least one (1) of the witnesses shall be a person who is not related to the resident by blood, marriage, or adoption and would not be entitled to any portion of the resident's estate upon his or her death. The advance directive shall contain a clause that attests that the witnesses comply with the requirements of this paragraph.

(4) Unless otherwise specified in an advance directive, the agent's authority becomes effective only upon a determination that the resident lacks capacity, and it ceases to be effective upon a determination that the resident has recovered capacity.

(5) An ACLF may use the model advance directive form that meets the requirements of the Tennessee Health Care Decisions Act and has been developed and issued by the Board for Licensing Health Care Facilities.

(6) The resident's designated physician shall make a determination that a resident either lacks or has recovered capacity. The designated physician shall also have authority to make a determination that another condition exists that affects an individual instruction or the authority of an agent. To make such determinations the resident's designated physician shall be authorized to consult with such other persons as the physician may deem appropriate.

(7) An agent shall make a health care decision in accordance with the resident's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the resident's best interest. In determining the resident's best interest, the agent shall consider the resident's personal values to the extent known.

(8) An advance directive may include the individual's nomination of a court-appointed guardian.

(9) An ACLF shall honor an advance directive that is executed outside of this state by a nonresident of this state at the time of execution if that advance directive is in compliance with the laws of Tennessee or the state of the resident's residence.

(10) No health care provider or institution shall require the execution or revocation of an advance directive as a condition for being insured for, or receiving, health care.

(11) Any living will, durable power of attorney for health care, or other instrument signed by the individual, complying with the terms of Tennessee Code Annotated, Title 32, Chapter 11, and a durable power of attorney for health care

complying with the terms of Tennessee Code Annotated, Title 34, Chapter 6, Part 2, shall be given effect and interpreted in accord with those respective acts. Any advance directive that does not evidence an intent to be given effect under those acts but that complies with these regulations may be treated as an advance directive under these regulations.

(12) A resident having capacity may revoke the designation of an agent only by a signed writing or by personally informing the supervising health care provider.

(13) A resident having capacity may revoke all or part of an advance directive, other than the designation of an agent, at any time and in any manner that communicates intent to revoke.

(14) A decree of annulment, divorce, dissolution of marriage, or legal separation revokes a previous designation of a spouse as an agent unless otherwise specified in the decree or in an advance directive.

(15) An advance directive that conflicts with a previously executed advance directive revokes the earlier directive to the extent of the conflict.

(16) Surrogates.

(a) An adult or emancipated minor may designate any individual to act as surrogate by personally informing, either orally or in writing, the supervising health care provider.

(b) A surrogate may make a health care decision for a resident who is an adult or emancipated minor if and only if:

1. the designated physician determines that the resident lacks capacity, and

2. there is not an appointed agent or guardian; or

3. the agent or guardian is not reasonably available.

(c) In the case of a resident who lacks capacity, the resident's current clinical record of the ACLF shall identify his or her surrogate.

(d) The resident's surrogate shall be an adult who has exhibited special care and concern for the resident, who is familiar with the resident's personal values, who is reasonably available, and who is willing to serve.

(e) Consideration may be, but need not be, given in order of descending preference for service as a surrogate to:

1. the resident's spouse, unless legally separated;

2. the resident's adult child;

3. the resident's parent;

4. the resident's adult sibling;

5. any other adult relative of the resident; or

6. any other adult who satisfies the requirements of 1200-08-25-.15(16)(d).

(f) No person who is the subject of a protective order or other court order that directs that person to avoid contact with the resident shall be eligible to serve as the resident's surrogate.

(g) The following criteria shall be considered in the determination of the person best qualified to serve as the surrogate:

1. Whether the proposed surrogate reasonably appears to be better able to make decisions either in accordance with the resident's known wishes or best interests;

2. The proposed surrogate's regular contact with the resident prior to and during the incapacitating illness;

3. The proposed surrogate's demonstrated care and concern;

4. The proposed surrogate's availability to visit the resident during his or her illness; and

5. The proposed surrogate's availability to engage in face-to-face contact with health care providers for the purpose of fully participating in the decision-making process.

(h) If the resident lacks capacity and none of the individuals eligible to act as a surrogate under 1200-08-25-.15(16)(c) thru 1200-08-25-.15(16)(g) is reasonably available, the designated physician may make health care decisions for the resident after the designated physician either:

1. Consults with and obtains the recommendations of a facility's ethics mechanism or standing committee in the facility that evaluates health care issues; or

2. Obtains concurrence from a second physician who is not directly involved in the resident's health care, does not serve in a capacity of decision-making, influence, or responsibility over the designated physician, and is not under the designated physician's decision-making, influence, or responsibility.

(i) In the event of a challenge, there shall be a rebuttable presumption that the selection of the surrogate was valid. Any person who challenges the selection shall have the burden of proving the invalidity of that selection.

(j) A surrogate shall make a health care decision in accordance with the resident's individual instructions, if any, and other wishes to the extent known to the surrogate. Otherwise, the surrogate shall make the decision in accordance with the surrogate's determination of the resident's best interest. In determining the resident's best interest, the surrogate shall consider the resident's personal values to the extent known.

(k) A surrogate who has not been designated by the resident may make all health care decisions for the resident that the resident could make on the resident's own behalf, except that artificial nutrition and hydration may be

withheld or withdrawn for a resident upon a decision of the surrogate only when the designated physician and a second independent physician certify in the resident's current clinical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the resident is highly unlikely to regain capacity to make medical decisions.

(l) Except as provided in 1200-08-25-.15(16)(m):

1. A designated surrogate may not be one of the following:

(i) the treating health care provider;

(ii) an employee of the treating health care provider;

(iii) an operator of a health care institution; or

(iv) an employee of an operator of a health care institution; and

2. A health care provider or employee of a health care provider may not act as a surrogate if the health care provider becomes the resident's treating health care provider.

(m) A designated surrogate may be an employee of the treating health care provider or an employee of an operator of a health care institution if:

1. the employee so designated is a relative of the resident by blood, marriage, or adoption; and

2. the other requirements of this section are satisfied.

(n) A health care provider may require an individual claiming the right to act as surrogate for a resident to provide written documentation stating facts and circumstances reasonably sufficient to establish the claimed authority.

(17) Guardian.

(a) A guardian shall comply with the resident's individual instructions and may not revoke the resident's advance directive absent a court order to the contrary.

(b) Absent a court order to the contrary, a health care decision of an agent takes precedence over that of a guardian.

(c) A health care provider may require an individual claiming the right to act as guardian for a resident to provide written documentation stating facts and circumstances reasonably sufficient to establish the claimed authority.

(18) A designated physician who makes or is informed of a determination that a resident lacks or has recovered capacity, or that another condition exists which affects an individual instruction or the authority of an agent, guardian, or surrogate, shall promptly record such a determination in the resident's current

clinical record and communicate the determination to the resident, if possible, and to any person then authorized to make health care decisions for the resident.

(19) Except as provided in 1200-08-25-.15(20) thru 1200-08-25-.15(22), a health care provider or institution providing care to a resident shall:

(a) comply with an individual instruction of the resident and with a reasonable interpretation of that instruction made by a person then authorized to make health care decisions for the resident; and

(b) comply with a health care decision for the resident made by a person then authorized to make health care decisions for the resident to the same extent as if the decision had been made by the resident while having capacity.

(20) A health care provider may decline to comply with an individual instruction or health care decision for reasons of conscience.

(21) A health care institution may decline to comply with an individual instruction or health care decision if the instruction or decision is:

(a) contrary to the institution's policy which is based on reasons of conscience, and

(b) the institution timely communicated the policy to the resident or to a person then authorized to make health care decisions for the resident.

(22) A health care provider or institution may decline to comply with an individual instruction or health care decision that requires medically inappropriate health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution.

(23) A health care provider or institution that declines to comply with an individual instruction or health care decision pursuant to 1200-08-25-.15(20) thru 1200-08-25-.15(22) shall:

(a) promptly inform the resident, if possible, and/or any other person then authorized to make health care decisions for the resident;

(b) provide continuing care to the resident until he can be transferred to another health care provider or institution or it is determined that such a transfer is not possible;

(c) immediately make all reasonable efforts to assist in the transfer of the resident to another health care provider or institution that is willing to comply with the instruction or decision unless the resident or person then authorized to make health care decisions for the resident refuses assistance; and

(d) if a transfer cannot be effected, the health care provider or institution shall not be compelled to comply.

(24) Unless otherwise specified in an advance directive, a person then authorized to make health care decisions for a resident has the same rights as the resident to request, receive, examine, copy, and consent to the disclosure of medical or any other health care information.

(25) A health care provider or institution acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for:

(a) complying with a health care decision of a person apparently having authority to make a health care decision for a resident, including a decision to withhold or withdraw health care;

(b) declining to comply with a health care decision of a person based on a belief that the person then lacked authority; or

(c) complying with an advance directive and assuming that the directive was valid when made and had not been revoked or terminated.

(26) An individual acting as an agent or surrogate is not subject to civil or criminal liability or to discipline for unprofessional conduct for health care decisions made in good faith.

(27) A person identifying a surrogate is not subject to civil or criminal liability or to discipline for unprofessional conduct if such identification is made in good faith.

(28) A copy of a written advance directive, revocation of an advance directive, or designation or disqualification of a surrogate has the same effect as the original.

(29) The withholding or withdrawal of medical care from a resident in accordance with the provisions of the Tennessee Health Care Decisions Act shall not, for any purpose, constitute a suicide, euthanasia, homicide, mercy killing, or assisted suicide.

(30) Universal Do Not Resuscitate Order (DNR).

(a) The Physicians Order for Scope of Treatment (POST) form, a form meeting the provisions of the Health Care Decision Act and approved by the Board for Licensing Health Care Facilities, may be used as the Universal Do Not Resuscitate Order by all facilities. A universal do not resuscitate order (DNR) may be used by a physician for his/her patient with whom he/she has a physician/patient relationship, but only:

1. with the consent of the patient; or

2. if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon the request of and with the consent of the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act; or

3. if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order and the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act is not reasonably available, the physician determines that the provision of cardiopulmonary resuscitation would be contrary to accepted medical standards.

(b) If the resident is an adult who is capable of making an informed decision, the resident's expression of the desire to be resuscitated in the event of cardiac or respiratory arrest shall revoke a universal do not resuscitate order. If the resident is a minor or is otherwise incapable of making an informed decision, the expression of the desire that the resident be resuscitated by the person authorized to consent on the resident's behalf shall revoke a universal do not resuscitate order.

(c) Universal Do Not Resuscitate orders shall remain valid and in effect until revoked. Qualified emergency medical services personnel, and licensed health care practitioners in any facility, program or organization operated or licensed by the board for licensing health care facilities or by the department of mental health and developmental disabilities or operated, licensed, or owned by another state agency are authorized to follow universal do not resuscitate orders.

(d) Nothing in these rules shall authorize the withholding of other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or to alleviate pain.

(e) When a person with a universal Do not Resuscitate order is transferred from one health care facility to another health care facility, the health care facility initiating the transfer shall communicate the existence of the universal Do Not Resuscitate order to the receiving facility prior to the transfer. The transferring facility shall assure that a copy of the universal do not resuscitate order accompanies the resident in transport to the receiving health care facility. Upon admission, the receiving facility shall make the universal do not resuscitate order a part of the resident's record. The POST from promulgated by the Board for Licensing Health Care Facilities shall serve as the Universal DNR when transferring a resident from one health care facility to another health care facility.

(f) This section shall not prevent, prohibit, or limit a physician from issuing a written order, other than a universal do not resuscitate order, not to resuscitate a resident in the event of cardiac or respiratory arrest in accordance with accepted medical practices.

(g) Valid Do Not Resuscitate orders or emergency medical services do not resuscitate orders issued before July 1, 2004, pursuant to the then-current law, shall remain valid and shall be given effect as provided.

Authority: T.C.A. §§ 68-11-209, 68-11-224, 68-11-1801, et *seq.*

1200-08-25-.16 Disaster Preparedness.

(1) An ACLF shall have in effect and available for all supervisory personnel and staff written copies of the following disaster, refuge and/or evacuation plans readily available at all times:

(a) Fire Safety Procedures Plan shall include:

1. Minor fires;

2. Major fires;

3. Fighting the fire;

4. Evacuation procedures; and

5. Staff functions.

(b) Tornado/Severe Weather Procedures Plan shall include:

1. Staff duties; and

2. Evacuation procedures.

(c) Bomb Threat Procedures Plan shall include:

1. Staff duties;

2. Search team, searching the premises;

3. Notification of authorities;

4. Location of suspicious objects; and,

5. Evacuation procedures.

(d) Flood Procedure Plan, if applicable, shall include:

1. Staff duties;

2. Evacuation procedures; and

3. Safety procedures following the flood.

(e) Severe Cold Weather and Severe Hot Weather Procedure Plans shall include:

1. Staff duties;

2. Equipment failures;

3. Evacuation procedures; and

4. Emergency food service.

(f) Earthquake Disaster Procedures Plan shall include:

1. Staff duties;

2. Evacuation procedures;

3. Safety procedures; and

4. Emergency services.

(2) An ACLF shall comply with the following:

(a) Maintain a detailed log with staff signatures designating training each employee receives regarding disaster preparedness.

(b) Train all employees annually as required in the plans listed above and keep each employee informed with respect to the employee's duties under the plans.

(c) Exercise each of the plans listed above annually.

(3) An ACLF shall participate in the Tennessee Emergency Management Agency local/county emergency plan on an annual basis. Participation includes:

(a) filling out and submitting a questionnaire on a form to be provided by the Tennessee Emergency Management Agency; and

(b) maintaining documentation of participation that shall be made available to survey staff as proof of participation.

(4) ACLFs which elect to have an emergency generator shall ensure that the generator is designed to meet the ACLF's HVAC and essential needs and shall have a minimum of twenty-four (24) hours of fuel designed to operate at its rated load. This requirement shall be coordinated with the Disaster Preparedness Plan or with the local resources.

(a) All generators shall be exercised for thirty (30) minutes each month under full load, including automatic and manual transfer of equipment.

(b) The emergency generator shall be operated at the existing connected load and not on dual power. The ACLF shall maintain a monthly log and have trained staff familiar with the generator's operation.

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

1200-08-25-.17 Appendix

(1) Physician Orders for Scope of Treatment (POST) Model Form

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED	
Physician Orders for Scope of Treatment (POST) This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.	Patient's Last Name First Name/Middle Initial Date of Birth
Section A Check One Box Only	CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and/or is not breathing. ☐ Resuscitate (CPR) ☐ Do Not Attempt Resuscitate (DNR/no CPR) When not in cardiopulmonary arrest, follow orders in B, C, and D.

Section B Check One Box Only	MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing. ☐ Comfort Measures Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location. ☐ Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care. ☐ Full Treatment. Includes care above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Include intensive care. Other Instructions:_____
Section C Check One Box Only	ANTIBIOTICS – Treatment for new medical conditions: ☐ No Antibiotics ☐ Antibiotics Other Instructions:_____
Section D Check One Box Only in Each Column	MEDICALLY ADMINISTERED FLUIDS AND NUTRITION. Oral fluids and nutrition must be offered if medically feasible. ☐ No IV fluids (provide other measures to assure comfort) ☐ No feeding tube ☐ IV fluids for a defined trial period ☐ Feeding tube for a defined trial period ☐ IV fluids long-term if indicated ☐ Feeding tube long-term Other Instructions:_____

Section E Must be Completed	Discussed with: ☐ Patient/Resident ☐ Health care agent ☐ Court-appointed guardian ☐ Health care surrogate ☐ Parent of minor ☐ Other:_____(Specify)	The Basis for These Orders Is: (Must be completed) ☐ Patient's preferences ☐ Patient's best interest (patient lacks capacity or preferences unknown) ☐ Medical indications ☐ (Other)_____	
	Physician Name (Print)	Physician Phone Number	Office Use Only
	Physician Signature (Mandatory)	Date	

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Significant thought has been given to life-sustaining treatment. Preferences have been expressed to a physician and/or health care professional(s). This document reflects those treatment preferences.

(If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.)

Signature	Name (print)	Relationship (write "self" if patient)

Contact Information

Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professionals

Completing POST

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

POST must be signed by a physician to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Photocopies/faxes of signed POST forms are legal and valid.

Using POST

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation".

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".

A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.

Reviewing POST

This POST should be reviewed if:

(1) The patient is transferred from one care setting or care level to another, or
(2) There is a substantial change in the patient's health status, or
(3) The patient's treatment preferences change.

Draw line through sections A through E and write "VOID" in large letters if POST is replaced or becomes invalid.

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

(2) Advance Care Plan Form

ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me:

Name:_____ Phone #: _____ Relation: _____

Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name:_____ Phone #: _____ Relation: _____

Address: _____

Quality of Life:

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (you can check as many of these items as you want):

☐ Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.

☐ Permanent Confusion: I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.

☐ Dependent in all Activities of Daily Living: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.

☐ End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

Treatment:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.

☐ Yes	☐ No	CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ Yes	☐ No	Life Support/Other Artificial Support: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
☐ Yes	☐ No	Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes	☐ No	Tube feeding/IV fluids: Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

Other instructions, such as burial arrangements, hospice care, etc.:_____

_____

_____

_____

(Attach additional pages if necessary)

Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues:

_____

_____

_____

SIGNATURE

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.

Signature: _____ Date: _____
(Patient)

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form. _____ Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form. _____ Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE
COUNTY OF_____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient". The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

Approved by Tennessee Department of Health, Board for Licensing Health Care Facilities, February 2, 2005
Acknowledgement to Project GRACE for inspiring the development of this form.

Authority: T.C.A. §§ 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.

* 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)
Dr. Larry Arnold	X				
Ms. Charlotte Burns	X				
Dr. Thomas Carr	X				
Ms. Elizabeth Chadwell	X				
Ms. Paula Collier	X				
Mr. Alex Gaddy				X	
Ms. Estelle Garner				X	
Mr. Robert Gordon				X	
Dr. Jennifer Gordon-Maloney	X				
Mr. Luke Gregory	X				
Mr. Mike Hann				X	
Dr. Norman Jones				X	
Mr. Carissa Lynch	X				
Ms. Annette Marlar	X				
Ms. Sara Snodgrass	X				
Ms. Dixie Taylor-Huff				X	
Mr. Carlyle Walton	X				
Mr. James Weatherington	X				
Dr. Jon Winter	X				

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 03/23/2009 (mm/dd/yyyy), and is in compliance with the provisions of TCA 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: *01/30/2009*

Notice published in the Tennessee Administrative Register on: *02/13/2009*

Rulemaking Hearing(s) Conducted on: (add more dates). *03/23/2009*

Date: 4/23/09

Signature: L. Erin Begley

Name of Officer: L. Erin Begley, Esq.

Title of Officer: Assistant General Counsel
Tennessee Department of Health

Subscribed and sworn to before me on: 4/23/2009

Notary Public Signature: Theodora P. Wilkins

My commission expires on: 11/7/2011

THEODORA P. WILKINS NOTARY PUBLIC AT LARGE DAVIDSON COUNTY, TENN.

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.

Robert E. Cooper, Jr.
Attorney General and Reporter

9-21-09
Date

Department of State Use Only

Filed with the Department of State on: 9/24/09

Effective on: 12/23/09

Tre Hargett by Mike Steel, POA
Tre Hargett
Secretary of State

RECEIVED
2009 SEP 24 PM 3: 29
SECRETARY OF STATE
PUBLICATIONS

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. §4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

Comments:

Comment 1:

The following comment was made by Michelle Bobo. Ms. Bobo presented at the rulemaking hearing as a representative of the Tennessee Association for Home Care (TAHC). Ms. Bobo commented that the current draft of the Assisted Care Living Facility (ACLF) rules omitted language found in Section 68-11-201(4)(C)(ii) of the Long-Term Care and Community Choices Act which reads, "nothing in subdivision (4) shall authorize assisted-care living facilities to provide medical services to assisted-care living facility residents if such services are reimbursable under the federal Medicare program. Ms. Bobo and TAHC recommended the following language be added to the rules at Section 1200-08-25-.07(4), "medical services reimbursable by the federal Medicare program shall be provided by a Medicare certified home health agency or Medicare certified hospice."

The Board voted not to add the language as proposed to the rules because the language limits medical services provided in an ACLF to those services provided by either a home health agency or hospice service. Instead, the Board voted to add the following language, "Medicare reimbursable services shall be provided to an ACLF resident by a certified Medicare provider."

Comment 2:

The following comment was made by Deborah Heeney. Ms. Heeney presented at the rulemaking hearing as a representative of the Tennessee Health Care Association (THCA). Ms. Henney provided both written and oral comments in which she recommended that the Board add the following language to 1200-08-25-.08(6)(c), an ACLF shall "[p]rior to admission provide an accurate written statement regarding fees and services provided by the facility and services provided by outside entities consistent with these rules and regulations, such as hospice services."

The Board voted not to add the language as proposed to the rules. The Board stated that an ACLF should not be held responsible for updating its contractors list. The Board expressed concern that the provision would place an added burden on ACLF providers without adding value to service provided. The Board further expressed concern that adding the proposed language would single out a particular service, in this instance hospice services.

Comment 3:

The following comment was made by Erin Begley, legal counsel for the Department of Health, Division of Health Care Facilities. Ms. Begley recommended that the Board add the following language to 1200-08-25-.04, "each ACLF administrator shall submit to the Department, an application fee of one hundred eighty dollars ($180.00). The fee shall be submitted with the application and is not refundable." Ms. Begley explained to the Board that the current ACLF rules provided that an ACLF administrator is to pay an application fee and an annual renewal fee of one hundred eighty dollars ($180.00). Ms. Begley explained that the proposed language was omitted from the current draft of the rules by mistake.

The Board voted to add the recommended language.

Regulatory Flexibility Addendum
Pursuant to Public Chapter 464 of the 105th General Assembly, prior to initiating the rule making process as described in § 4-5-202(a)(3) and § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

STATEMENT OF ECONOMIC IMPACT TO SMALL BUSINESSES

Name of Board, Committee or Council: Tennessee Department of Health, Division of Licensure for Health Care Facilities

Rulemaking hearing date: March 23, 2009

Types of small businesses that will be directly affected by the proposed rules:

These rule changes only affect assisted-care living facilities. Their impact on small businesses is expected to be negligible.

Types of small businesses that will bear the cost of the proposed rules:

The rule changes impact assisted-care living facilities and would have minimal affect on any small businesses.

Types of small businesses that will directly benefit from the proposed rules:

None known.

Description of how small business will be adversely impacted by the proposed rules:

The rule changes should have little adverse impact on small business as they primarily affect hospitals.

Alternatives to the proposed rule that will accomplish the same objectives but are less burdensome, and why they are not being proposed:

The Department of Health, Division for Licensing Health Care Facilities does not believe there are less burdensome alternatives to the proposed rule amendments.

Comparison of the proposed rule with federal or state counterparts:

Federal: The Department of Health, Division for Licensing Health Care Facilities is not aware of any federal counterparts.

State: The proposed rule amendments regarding hospitals will have no state counterpart because the Department of Health, Division for Licensing Health Care Facilities is the only agency charged with regulating hospitals.

(If applicable, insert Regulatory Flexibility Addendum here)

Regulatory Flexibility Analysis

(1) The proposed rules do not overlap, duplicate, or conflict with other federal, state, or local government rules.

(2) The proposed rules exhibit clarity, conciseness, and lack of ambiguity.

(3) The proposed rules are not written with special consideration for the flexible compliance and/or requirements because the licensing boards have, as their primary mission, the protection of the health, safety and welfare of Tennesseans. However, the proposed rules are written with a goal of avoiding unduly onerous regulations. The rule regarding medical laboratories in hospitals is written to clarify the types of laboratories required. The rule regarding electronic record keeping of the declination of flu vaccination is written to simplify record keeping requirements for hospitals that have been determined necessary by the Hospital Acquired Infection Taskforce as set forth in T.C.A. § 68-11-264.

(4) The compliance requirements throughout the proposed rules are as "user-friendly" as possible while still allowing the Division to achieve its mandated mission in licensing health care facilities. There is sufficient notice between the rulemaking hearing and the final promulgation of rules to allow services and providers to come into compliance with the proposed rules.

(5) Compliance requirements are not consolidated or simplified for small businesses in the proposed rules for the protection of the health, safety and welfare of Tennesseans.

(6) The standards required in the proposed rules are very basic and do not necessitate the establishment of performance standards for small businesses.

(7) There are no unnecessary entry barriers or other effects in the proposed rules that would stifle entrepreneurial activity or curb innovation. The decreased cost for record keeping for hospitals are minimal, but electronic record keeping will be sufficient to protect the health, safety and welfare of Tennesseans.

>?"

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to TCA 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;

Chapter 1200-08-25 Standards for Assisted-Care Living Facilities ("ACLF"), is amended by deleting it in its entirety, and amending the chapter to effectuate the requirements for assisted-care living facilities included in Chapter 1190 of the Public Acts of 2008. The old chapter did not include the above.
1200-08-25-.01 Purpose-The old rule did not include the purpose of assisted-care living services. The new rule includes the above.
1200-08-25-.02 Definitions-The old rule did not include the following: 1200-08-25-.02(3) that an individual could qualify as an ACLF administrator if that individual is currently licensed in Tennessee as a nursing home administrator as required by T.C.A. §§ 63-16-101, et seq.; 1200-08-25-.02(6) definition of an ACLF to mean a building, establishment, complex or distinct part thereof that accepts primarily aged persons for domiciliary care and services; 1200-08-25-.02(7) expansion of the definition of an assisted-care living resident to make it consistent with Chapter 1190 with the focus upon whether or not the resident's needs can be safely and effectively met at the ACLF as certified by the resident's treating physician and in accordance with these rules with a focus on the changing culture in ACLF's. The new rule includes the above.
1200-08-25-.03 Licensing Requirements-The old rule did not include the following: 1200-08-25-.03(1) requirements to ensure the legitimacy of the applicant for licensing including a nonrefundable application fee, a financial statement prepared by a certified public accountant, a copy of a local business license if required, and a copy of any and all documents demonstrating the legal status of the business organization owning the ACLF; 1200-08-25-.03(4) (b), (c), and (d) allowance of a sixty day grace period to renew license including a late renewal penalty fee of $100.00 per month for late renewal; and requirements for new application, fee and inspection should the licensee wish to renew and has failed to do so within the 60 day grace period; 1200-08-25-.03 (8)(b) requirements that a prospective new owner must submit the following to obtain a change of ownership: completed change of ownership application; nonrefundable application fee; demonstration of ability to meet financial obligations with financial statement prepared by a certified public accountant; copy of local business license if required; copy of documentation of formation of business organization owning ACLF; bill of sale/and or closing documents indicating transfer of operations; and 1200-08-25-.03(9)(c)6 requirement that an ACLF administrator who has allowed his certification to lapse must show proof of at least 24 classroom hours of continuing education upon reapplication. The new rule includes the above.
Rule 1200-08-25-.04 Fees-Moved from old rule 1200-8-25-.02(4) with no material change.
Rule 1200-08-25-.05 Regulatory Standards-The old rule did not include the following: 1200-08-25-.05(5) Civil Penalties – Authorizes the Board to assess civil penalties of $0-$1000 for violation of T.C.A. § 68-11-201(4)(B) (Provision of Room and Board and Non-Medical Living Assistance Services) and $0-$1000 for violation of § 68-11-201(4)(C) (Provision of Medical and other professional services, Medicare services; Oversight of Medical Services; Plan of Care & Assessment; Personal and Medical Records; and Fire Safety. In determining the amount of any civil penalty the Board may consider the following: willfulness of the violation; repetitiveness of the violation, and magnitude of the risk of harm caused by the violation. The new rule includes the above.
Rule 1200-08-25-.06 Administration – There were no material changes to this section except that the old rule did not include the following: 1200-08-25-.06(3) Allows a registered nurse to make the actual determination and pronouncement of death for a resident who dies at an ACLF while receiving services of a registered nurse under the following circumstances: a) the deceased was suffering from a terminal illness; b) death was anticipated and the attending physician has agreed in writing to sign the death certificate (agreement must be in place and with deceased at time of death); c) nurse is licensed by the Tenn. Board of Nursing; and d) the nurse is employed by the hospice program from which the deceased had been receiving hospice services. The new rule includes the above.
Rule 1200-08-25-.07 – Services Provided. The old rule did not include the following: 1200-08-25-.07(1) An ACLF may provide medical services as follows: (a) administer medications to residents

that are typically self-administered subject to limitation of these rules and regulations; (b) all other medical services prescribed by a physician that could be provided to a private citizen in the citizen's home (including at least the following: part-time or intermittent nursing care, various therapies, podiatry care, medical social services, medical supplies, durable medical equipment, and hospice services); administration of self-administered medication excluding intravenous injections that may only be administered to: existing residents who receive them on an intermittent basis and residents on hospice care.
1200-08-25-.07(2)Medical services in an ACLF shall be provided by appropriately licensed or qualified staff of an ACLF, appropriately licensed or qualified contractors of an ACLF, a licensed home care organization, another appropriately licensed entity; or appropriately licensed staff of a nursing home.
1200-08-25-.07(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 applicable licensing boards and shall ensure quality of care to residents.
1200-08-25-.07(5) An ACLF shall dispose of medications in the following manner: a) Upon discharge or death of a resident, unused medications shall be released to the resident, family member, or legal representative unless specifically prohibited by the attending physician or other authorized healthcare provider; b) any scheduled drug that is misbranded, expired, deteriorated, or not kept under proper conditions or in containers with illegible or missing labels shall be returned to the pharmacy within 5 working days after discovery for proper disposition by a licensed pharmacist; and c) any non-scheduled drug or device that is misbranded, expired, deteriorated, or not kept under proper conditions or in containers with illegible or missing labels shall be properly disposed of at the ACLF in the presence of another licensed or certified professional.
1200-08-25-.07(6)(a) Each ACLF shall provide each resident with at least the following personal services (protective care, safety when in the ACLF, daily awareness of the individual's whereabouts, the ability and readiness to intervene if crises arise, room and board, and non-medical living assistance with activities of daily living.
The new rule includes the above.

Rule 1200-08-25-.08 – Admissions, Discharges, and Transfers. The old rule did not include the following:
1200-08-25-.08(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, no including psychotropic medications for a manageable mental disorder or condition; or f) has needs that cannot be safely and effectively met in the ACLF.
1200-08-25-.08(2) An ACLF resident shall be discharged and transferred to another appropriate setting when the resident, the resident's legal representative, ACLF administrator, or the resident's treating physician determine that an ACLF cannot safely and effectively meet the resident's needs, including medical services. The rule further provides that the Board may require an ACLF resident to 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.
1200-08-25-.08(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: a) the resident's treating physician, certifies in writing that the resident's needs, including medical services, can be 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.
1200-08-25-.08(4) An ACLF shall not admit, but may permit the continued stay of residents who require the following:

a) The following treatments on an intermittent basis of up to three (3) twenty-one (21) day periods: 1) nasopharyngeal or tracheotomy aspiration; 2) nasogastric feedings; 3) gastrostomy feedings; or 4) intravenous therapy or intravenous feedings. (The resident's physician must certify that treatment can be safely and effectively provided by the ACLF for the last two (2) twenty-one (21) day periods.)
b) The treatments described in (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 self-care for the specified conditions.

1200-08-25-.08(5) An ACLF resident who qualifies for hospice care shall be able to receive hospice services and continue as a resident if the resident's treating physician certifies that such care can be appropriately provided in the ACLF.

(a) If a 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 prepared pursuant to current hospice guidelines promulgated by CMS 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 cooperation with the ACLF.
1200-08-25-.08(7) Each ACLF shall have documented plans and procedures to show evacuation of all residents.
1200-08-25-.08(8) An ACLF may not retain a resident who cannot evacuate within thirteen (13) minutes unless it 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.
The new rules include the above to comply with Public Chapter 1190 of the 2008 Public Acts.

Rules 1200-08-25-.09 - Building Standards-This rules has been completely reorganized with no material changes except for the following:
Rule 1200-089-25-.09 (2) has been changed to include that new facilities shall conform to the 2006 edition of the International Building Code, the 2006 edition of the National Fire Protection Code (NFPA), the 2005 edition of the National Electrical Code, and the 199 edition of the U.S. Public Health Service Food Code. The requirements of the American Disabilities Act, as revised in 2004 and the 1999 edition of North Carolina Handicap Accessibility Codes, with 2004 amendments, shall apply to all new and existing facilities.
The new rule includes the above additional compliance requirements.

Rule 1200-08-25-.10 – Life Safety. There have been no material changes to this rule except to add the following: Rules 1200-08-25(6)(d) has been amended to include that the designated smoking room in an ACLF shall not be an individual resident's sleeping unit.

Rule 1200-08-25-.11- Infectious and Hazardous Waste. There have been no material changes to this rule.

Rule 1200-08-25-.12 – Resident Records. The old rule did not require both a personal record for each ACLF resident and a medical record. The old rule did not include the following:
1200-08-25-.12(3) Medical record. An ACLF shall ensure that its employees develop and maintain a medical record for each resident who requires health care services at the ACLF regardless of whether such services are rendered by the ACLF or by arrangement with an outside source.
1200-08-25-.12-(5) Plan of care. An ACLF shall develop a plan of care for each resident it admits within five (5) days of admission. The following must be included in development of the plan of care: resident or the resident's legal representative, treating physician, or other licensed health care professionals or entity delivering patient services. The plan of care shall describe: needs of the resident; requirements and arrangements for visits by or to physicians or other authorized health providers; advance care directive and/or health care power-of-attorney; as applicable; recreational and social activities which are suitable, desirable, and important to the well-being of the resident; and dietary needs.
The new rule includes the above.

Rule 1200-08-25-.13 – Reports. There have been no material changes to this rule.

Rule 1200-08-25-.14 – Resident Rights. There have been no material changes to this rule.

Rule 1200-08-25-.15 – Policies and Procedures for Health Care Decision-Making. This rule was changed at 1200-08-25-.15(30) to state that the Physician Order for Scope of Treatment (POST) form may be used as the Universal Do Not Resuscitate Order. The rule was further changed at (30)(e) requiring the form the mandatory UNDR form to be used when transferring a resident from one health care facility to another health care facility. This rule change deleted the provision making the POST mandatory for use in an ACLF in all situations.

Rule 1200-08-25-.16 – Disaster Preparedness. There have been no material changes to this rule.

Rule 1200-08-25-.17 – Appendix I. There have been no material changes to this rule.

(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;

T.C.A. § 68-11-209 grants the Board for Licensing Health Care Facilities the duty and power to promulgate rules and regulations pertaining to the operation of health care facilities as are necessary to the public interest.
Public Chapter 1190 grants the Board for Licensing Health Care Facilities the authority to promulgate rules consistent with those found in the provisions found in the Governor's Long Term and Community Choices Act.

(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;

The Board for Licensing Health Care Facilities urges the adoption of the above rules amendments.

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

None.

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

Vincent Davis, Director, Division for Licensing Health Care Facilities;
L. Erin Begley, Assistant General Counsel, Tennessee Department of Health

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

Vincent Davis, Director, Division for Licensing Health Care Facilities and L. Erin Begley, Assistant General Counsel, Tennessee Department of Health

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

Vincent Davis: Tennessee Department of Health, Bureau of Health Licensure and Regulation, Division of Health Care Facilities, 227 French Landing, Suite 501, Heritage Place MetroCenter, Nashville, TN 37243, (615) 741-7221.
L. Erin Begley, Esq.: Office of General Counsel, 220 Athens Way, Suite 210, Nashville, TN 37243, (615) 741-1611.

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

None.