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File Date: 10/27/2021

Notice of Rulemaking Hearing

Hearings will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, T.C.A. § 4-5-204. For questions and copies of the notice, contact the person listed below.

Agency/Board/Commission:	Board for Licensing Health Care Facilities
Division:	Department of Health
Contact Person:	Kyonzté Hughes-Toombs
Address:	665 Mainstream Drive, Nashville, Tennessee 37243
Phone:	(615) 741-1611
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Any Individuals with disabilities who wish to participate in these proceedings (to review these filings) and may require aid to facilitate such participation should contact the following at least 10 days prior to the hearing:

ADA Contact:	ADA Coordinator
Address:	710 James Robertson Parkway, Andrew Johnson Building, 5th Floor, Nashville, Tennessee 37243
Phone:	(615) 741-6350
Email:	Tina.M.Harris2@tn.gov

Hearing Location(s) (for additional locations, copy and paste table)

Address 1:	Metro Center		
Address 2:	665 Mainstream Drive, Iris Conference Room		
City:	Nashville, TN		
Zip:	37228		
Hearing Date:	02/02/2022		
Hearing Time:	9:00 A.M.	_X_ CST/CDT ___ EST/EDT	

Additional Hearing Information:

Revision Type (check all that apply):
_X_ Amendment
___ New
___ Repeal

Rule(s) (**ALL** chapters and rules contained in filing must be listed. If needed, copy and paste additional tables to accommodate more than one chapter. Please enter only **ONE** Rule Number/Rule Title per row.)

Chapter Number	**Chapter Title**
1200-08-01	Standards for Hospitals
Rule Number	**Rule Title**
1200-08-01-.01	Definitions
1200-08-01-.06	Basic Hospital Functions

Chapter Number	Chapter Title
1200-08-06	Standards for Nursing Homes
Rule Number	**Rule Title**
1200-08-06-.01	Definitions
1200-08-06-.03	Disciplinary Procedures
1200-08-06-.04	Administration
1200-08-06-.05	Admissions, Discharges, and Transfers
1200-08-06-.06	Basic Services
1200-08-06-.07	Special Services: Alzheimer's Units
1200-08-06-.08	Building Standards
1200-08-06-.09	Life Safety
1200-08-06-.10	Infectious and Hazardous Waste
1200-08-06-.12	Resident Rights
1200-08-06-.15	Nurse Aide Competency Evaluation

Chapter Number	Chapter Title
1200-08-10	Standards for Ambulatory Surgical Treatment Centers
Rule Number	**Rule Title**
1200-08-10-.01	Definitions
1200-08-10-.04	Administration
1200-08-10-.11	Records and Reports

Chapter Number	Chapter Title
1200-08-11	Standards for Homes for the Aged
Rule Number	**Rule Title**
1200-08-11-.01	Definitions
1200-08-11-.02	Licensing Procedures
1200-08-11-.05	Admissions, Discharges and Transfers
1200-08-11-.09	Infectious and Hazardous Waste

Chapter Number	Chapter Title
1200-08-25	Standards for Assisted-Care Living Facilities
Rule Number	**Rule Title**
1200-08-25-.06	Administration
1200-08-25-.08	Admissions, Discharges, and Transfers
1200-08-25-.09	Building Standards
1200-08-25-.10	Life Safety
1200-08-25-.11	Infectious and Hazardous Waste

Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to https://sos.tn.gov/products/division-publications/rulemaking-guidelines.

Chapter 1200-08-01
Standards for Hospitals

Amendments

Rule 1200-08-01-.01 Definitions is amended by adding new paragraphs (9), (10), (47) and (84) and renumbering the remaining paragraphs accordingly, and is further amended by deleting part (a)5 from newly re-numbered paragraph (39) in its entirety and re-lettering the remaining part so that as amended, the new paragraphs shall read:

(9) Central Services Department. A department within a healthcare facility that processes, issues, and controls medical supplies, devices and equipment, both sterile and nonsterile, for patient care areas of a healthcare institution.

(10) Central Services Technician. A person who decontaminates, inspects, assembles, packages, and sterilizes reusable medical instruments or devices in a healthcare institution, whether such person is employed by the healthcare institution or provides services pursuant to a contract with the healthcare institution.

(47) "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.

(84) Sentinel Event. An unexpected occurrence involving death or serious physical injury, or the risk thereof. Serious injury specifically includes loss of limb or function.

Authority: T.C.A. §§ 39-11-106, 68-11-202, 68-11-204, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-224, 68-11-255, 68-11-1802, 68-57-101, 68-57-102, 68-57-105, and 2016 Public Chapter 1004.

Rule 1200-08-01-.06 Basic Hospital Functions is amended by deleting subparagraph (3)(k), but not its parts, and substituting instead the following language, and is further amended by adding new subparagraph (3)(l) and re-lettering the remaining subparagraphs, so that as amended, the new subparagraphs shall read:

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

(l) No person shall practice as a central service technician unless the person:

1. Has successfully passed a nationally accredited central service exam for central service technicians and holds and maintains one (1) of the following credentials:

(i) A certified registered central service technician credential administered by the International Association of Healthcare Central Service Material Management; or

(ii) A certified sterile processing and distribution technician credential administered by the Certification Board for Sterile Processing and Distribution, Inc.; or

(iii) Was employed or otherwise contracted for services as a central service technician in a healthcare institution before January 1, 2017; or

(iv) Obtains a certified registered central service technician credential administered by the International Association of Healthcare Central Service Material

Management or the Certification Board for Sterile Processing and Distribution, Inc., not later than two (2) years after the person's date of hire or contracting for services with a healthcare institution.

2. A central service technician shall complete a minimum of ten (10) hours of continuing education within a calendar year. The continuing education shall be in areas related to the functions of a central service technician. Continuing education shall be maintained in the employee's personnel file. National certification shall satisfy this requirement.

3. Nothing in this section shall prohibit the following persons from performing the tasks or functions of a central service technician:

   (i) A healthcare provider operating within the scope of practice for that provider established pursuant to title 63;

   (ii) A surgical technologist operating within the scope of practice established by § 68-57-105;

   (iii) A student or intern performing the functions of a central service technician under the direct supervision of a healthcare provider as part of the student's or intern's training or internship; or

   (iv) A person who does not work in a central service department in a healthcare facility, but who has been specially trained and determined competent, based on standards set by a healthcare institution's infection prevention or control committee, acting in consultation with a central service technician certified in accordance with subsection (b), to decontaminate or sterilize reusable medical equipment, instruments, or devices, in a manner that meets applicable manufacturer's instructions and standards.

4. A healthcare institution shall retain a list of persons determined to be competent under subsection (d). The list shall include job titles for such persons. A person determined to be competent pursuant to subsection (d) shall annually complete a minimum of ten (10) hours of continuing education in areas related to infection control and the decontamination and sterilization of reusable medical equipment, instruments and devices.

5. Any healthcare institution that employs or contracts with a central service technician shall submit to the department of health, upon request, including, but not limited to, during an inspection performed pursuant to this part, documentation demonstrating that the central service technician complies with the requirements of this section.

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

Chapter 1200-08-06
Standards for Nursing Homes

Amendments

Rule 1200-08-06-.01 Definitions is amended by deleting paragraphs (35), (44), and (57) in their entirety and substituting instead the following language, so that as amended, the new paragraphs shall read:

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

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

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

Aide Training Program are met.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 39-11-106, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-224, 68-11-234, 68-11-1802, and 71-6-121.

Rule 1200-08-06-.03 Disciplinary Procedures is amended by deleting paragraphs (3), (6), and (7) and substituting instead the following language, so that as amended, the new paragraphs shall read:

(3) The Board shall have the authority to place a facility on probation. To be considered for probation, a facility must have had at least two (2) separate substantiated complaint investigation surveys within six (6) months, where each survey had at least one deficiency cited at the level of substandard quality of care or immediate jeopardy, as those terms are defined at 42 CFR 488.301. None of the surveys can have been initiated by an unusual event or incident self-reported by the facility.

(6) The Board is authorized at any time during the probation to remove the probation status from the facility's license, based upon information presented to it showing that the conditions identified by the board have been corrected and are reasonably likely to remain corrected.

(7) The Board must rescind the probation status of the facility if it determines that the facility has complied with its plan of correction as submitted and approved by the board, unless the facility has additional non-compliance that warrants an additional term of probation as defined in T.C.A. § 68-11-207(e)(1).

Authority: T.C.A. §§ 4-5-202, 4-5-204, 4-5-219, 4-5-312, 4-5-316, 4-5-317, 68-11-202, 68-11-204, and 68-11-206 through 68-11-209.

Rule 1200-08-06-.04 Administration is amended by deleting subparagraph (4)(a) in its entirety and substituting instead the following language, so that as amended the new subparagraph shall read:

(4) (a) The term "unexpected loss" means the absence of a nursing home administrator due to serious illness or incapacity, unplanned hospitalization, death, resignation with less than thirty (30) days' notice or unplanned termination.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 39-17-1803, 39-17-1804, 39-17-1805, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-225, 68-11-254, 68-11-256, 68-11-257, 68-11-268, 68-11-906, and 71-6-121.

Rule 1200-08-06-.05 Admissions, Discharges, and Transfers is amended by deleting part (5)(h)1 and subparagraph (13)(b) in their entirety and substituting instead the following language, so that as amendment, the part and subparagraph shall read:

(5) (h) 1. Basic facts about the causes, progression and management of Alzheimer's disease and related disorders;

(b) The proximity of the proposed nursing home to the present nursing home and to the family and friends of the resident.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-257, and 71-6-121.

Rule 1200-08-06-.06 Basic Services is amended by deleting subparagraph (1)(a), (3)(b), (4)(b) and part (5)(i)1 in their entirety and substituting instead the following language, and is further amended by adding new subparagraphs (4)(o), (4)(x), (4)(bb), so that as amended, the new subparagraphs and part shall read:

(1) (a) The nursing home must ensure that there is an effective, facility-wide performance improvement program to evaluate resident care and performance of the organization.

(3) (b) The physical environment shall be maintained in such a manner to assure the safety and wellbeing of the residents.

(4) (b) The facility must have a well-organized nursing service with a plan of administrative authority and delineation of responsibilities for resident care. The Director of Nursing (DON) must be a licensed registered nurse who has no current disciplinary actions against his/her license. The

DON is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the facility.

(o) Patients who are bedfast shall have a sponge bath each day.

(x) Whenever a chemical restraint is administered, the patient shall be observed for adverse reaction and, if found, the drug shall be discontinued immediately and the physician notified.

(bb) Restraints must be applied in a manner by which they can be speedily removed in case of fire or other emergency.

(5) (i) 1. Evidence of a physical examination, including a health history, performed no more than sixty (60) days prior to admission;

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-3-511, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.

Rule 1200-08-06-.06 Basic Services is amended by deleting subparagraphs (9)(e), (9)(f), (9)(k), (9)(m) and (9)(o) in their entirety and substituting the following language, so that as amended, the new subparagraphs shall read:

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

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

(k) All nursing homes shall have commercial automatic dishwashers approved by the National Sanitation Foundation. Dishwashing machines shall have a hot water supply of one hundred forty degrees Fahrenheit (140° F) to one hundred sixty degrees Fahrenheit (160° F) for washing and one hundred eighty degrees Fahrenheit (180° F) for sanitizing, if within the original design capacity of the machine.

(m) The cleaning and sanitizing of hand washed dishes shall be accomplished by using a three-compartment sink according to the current "U.S. Public Health Service Sanitation Manual".

(o) All refrigerators and freezers shall have thermometers. Refrigerators shall have thermometers. Refrigerators shall be kept at an air temperature not to exceed forty-five degrees Fahrenheit (45° F) whenever food is stored in the unit. Freezers shall be kept at an air temperature sufficient for stored foods to remain frozen, but freezer air temperatures shall never exceed twenty degrees Fahrenheit (20° F).

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

Rule 1200-08-06-.07 Special Services: Alzheimer's Units is amended by deleting the introductory paragraph, subparagraph (1)(b), paragraph (2), subparagraph (10)(a), and paragraph (11) in their entirety and substituting instead the following language, so that as amended, the new introductory paragraph shall read:

Structurally distinct parts of a nursing home may be designated as special care units for ambulatory residents with dementia or Alzheimer's disease and related disorders. Such units shall be designed to encourage self-sufficiency, independence and decision-making skills, and may admit residents only after the unit is found to be in compliance with licensure standards and upon final approval by the department. Units which hold themselves out to the public as providing specialized Alzheimer's services shall comply with the provisions of T.C.A. § 68-11-1404 and shall be in compliance with the following minimum standards:

(1) (b) The need for admission must be determined by an interdisciplinary team consisting at least of a physician experienced in the management of residents with Alzheimer's disease and related disorders, a social worker, a registered nurse and a relative of the resident or a resident care

advocate.

(2) Special care units shall be separated from the remaining portion of the nursing home by a locked door and must have extraordinary and acceptable fire safety features and policies which ensure the wellbeing and protection of the residents.

(10) (a) Basic facts about the causes, progression and management of Alzheimer's disease and related disorders;

(11) Each resident shall have a treatment plan developed, periodically reviewed and implemented by an interdisciplinary treatment team consisting at least of a physician experienced in the management of residents with Alzheimer's disease and related disorders, a registered nurse, a social worker, an activity coordinator and a relative of the resident or a resident care advocate.

Authority: T.C.A. §§ 4-5-202, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-1404.

Rule 1200-08-06-.08 Building Standards is amended by deleting subparagraphs (13)(f) and (17)(c) in their entirety and substituting instead the following language, so that as amended, the new subparagraphs shall read:

(13) (f) Ground-Fault Circuit Interrupters (GFCI) that are required in all wet areas, such as kitchens, laundries, janitor closets, bath and toilet rooms, etc., and within six (6) feet of any lavatory.

(17) (c) Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at shower and bathing facilities shall not exceed one hundred twenty degrees Fahrenheit (120oF).

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-57, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-261.

Rule 1200-08-06-.09 Life Safety is amended by deleting paragraph (2) in its entirety and substituting instead the following language, so that as amended, the new paragraph shall read:

(2) The nursing home shall provide fire protection by the elimination of fire hazards, by the installation of necessary firefighting equipment and by the adoption of a written fire control plan. Fire drills shall be held at least quarterly for each work shift for nursing home personnel in each separate patient-occupied nursing home building. There shall be a written report documenting the evaluation of each drill and the action recommended or taken for any deficiencies found. Records which document and evaluate these drills must be maintained for at least three (3) years. All fires which result in a response by the local fire department shall be reported to the department within seven (7) days. The report shall contain sufficient information to ascertain the nature and location of the fire, its probable cause and any injuries incurred by any person or persons as a result of the fire. Initial reports by the facility may omit the name(s) of resident(s) and parties involved, however, should the department find the identities of such persons to be necessary to an investigation, the facility shall provide such information.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.

Rule 1200-08-06-.10 Infectious and Hazardous Waste is amended by deleting subparagraph (5)(a) and (8)(a) in their entirety and substituting instead the following language, so that as amended, the new subparagraph shall read:

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

(8) (a) A facility 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 conditions were met for proper sterilization or disinfection of materials included in the cycle, and records kept. Proper operation of such devices must be verified at least monthly, and records of these monthly checks 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.

Authority: T.C.A. §§ 4-5-202, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.

Rule 1200-08-06-.12 Resident Rights is amended by deleting subparagraph (1)(d) in its entirety and substituting instead the following language, so that as amended, the new subparagraph shall read:

(1) (d) To be different, in order to promote social, religious and psychological wellbeing;

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-901, and 68-11-902.

Rule 1200-08-06-.15 Nurse Aide Training and Competency Evaluation is amended by deleting paragraph (4) in its entirety and substituting instead the following language, so that as amended, the new paragraph shall read:

(4) Continued Competency. The facility must complete a performance review of each nurse aide employee at least once every 12 months and must provide regular in-service education based on the outcome of these reviews. Each nurse aide must receive at least ten (10) hours of training each year, and a record verifying attendance shall be kept in the nursing home files.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, and 68-11-804.

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

Amendments

Rule 1200-08-10-.01 Definitions is amended by deleting paragraph (7) in its entirety and substituting instead the following language, and is further amended by adding new paragraphs (12), (13) and (67) and renumbering the remaining paragraphs, so that as amended, the new paragraphs shall read:

(7) Ambulatory surgical treatment center (ASTC). Any institution, place or building devoted primarily to the maintenance and operation of a facility for the performance of surgical procedures. Such facilities shall not provide beds or other accommodations for the stay of a patient to exceed twelve (12) hours duration, provided that the length of stay may be extended for an additional twelve (12) hours in the event such stay is deemed necessary by the attending physician, the facility medical director, or the anesthesiologist for observation or recovery, but in no event shall the length of stay exceed twenty-four (24) hours. Individual patients shall be discharged in an ambulatory condition without danger to the continued well-being of the patients or shall be transferred to a hospital. Excluded from this definition are the private physicians' and dentists' office practices. For the purposes of this rule, those medical and dental offices, facilities, and other settings at which surgical procedures exclusively are performed are ASTC’s and not private office practices. Surgical procedures that generally result in extensive blood loss, require major or prolonged invasion of body cavities, or are considered emergency or life-threatening in nature may not be performed.

(12) Central Services Department. A department within a healthcare facility that processes, issues, and controls medical supplies, devices and equipment, both sterile and nonsterile, for patient care areas of a healthcare institution.

(13) Central Services Technician. A person who decontaminates, inspects, assembles, packages, and sterilizes reusable medical instruments or devices in a healthcare institution, whether such person is employed by the healthcare institution or provides services pursuant to a contract with the healthcare institution.

(67) Sentinel Event. An unexpected occurrence involving death or serious physical injury, or the risk thereof. Serious injury specifically includes loss of limb or function.

Authority: T.C.A. §§ 39-11-106, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-211, 68-11-216, 68-11-224, 68-11-1802, 68-57-101, 68-57-102, 68-57-105 and 2016 Public Chapter 1004.

Rule 1200-08-10-.04 Administration is amended by deleting part (20)(c)1 in its entirety and substituting instead the following langue, and is further amended by adding new subparagraph (20)(i), so that as amended, the new part and subparagraph shall read:

(20) (c) 1. Written control policies;

(20) (i) Unless otherwise permitted pursuant to this section, no person shall practice as a central service technician unless the person:

1. Has successfully passed a nationally accredited central service exam for central service technicians and holds and maintains one (1) of the following credentials:

(i) A certified registered central service technician credential administered by the International Association of Healthcare Central Service Material Management; or

(ii) A certified sterile processing and distribution technician credential administered by the Certification Board for Sterile Processing and Distribution, Inc.; or

(iii) Was employed or otherwise contracted for services as a central service technician in a healthcare institution before January 1, 2017; or

(iv) Obtains a certified registered central service technician credential administered by the International Association of Healthcare Central Service Material Management or the Certification Board for Sterile Processing and Distribution, Inc., not later than two (2) years after the person's date of hire or contracting for services with a healthcare institution.

2. A central service technician shall complete a minimum of ten (10) hours of continuing education within a calendar year. The continuing education shall be in areas related to the functions of a central service technician. Continuing education shall be maintained in the employee’s personnel file. National certification shall satisfy this requirement.

3. Nothing in this section shall prohibit the following persons from performing the tasks or functions of a central service technician:

(i) A healthcare provider operating within the scope of practice for that provider established pursuant to title 63;

(ii) A surgical technologist operating within the scope of practice established by § 68-57-105;

(iii) A student or intern performing the functions of a central service technician under the direct supervision of a healthcare provider as part of the student's or intern's training or internship; or

(iv) A person who does not work in a central service department in a healthcare facility, but who has been specially trained and determined competent, based on standards set by a healthcare institution's infection prevention or control committee, acting in consultation with a central service technician certified in accordance with subsection (b), to decontaminate or sterilize reusable medical equipment, instruments, or devices, in a manner that meets applicable manufacturer's instructions and standards.

4. A healthcare institution shall retain a list of persons determined to be competent under subsection (d). The list shall include job titles for such persons. A person determined to be competent pursuant to subsection (d) shall annually complete a minimum of ten (10) hours of continuing education in areas related to infection control and the

decontamination and sterilization of reusable medical equipment, instruments and devices.

5. Any healthcare institution that employs or contracts with a central service technician shall submit to the department of health, upon request, including, but not limited to, during an inspection performed pursuant to this part, documentation demonstrating that the central service technician complies with the requirements of this section.

(21) (g) Each ambulatory surgical treatment center in which more than fifty (50) surgical abortions are performed within a year shall conduct a mandatory interim assessment of the facility's compliance with quality measures as specified by the Board. Those quality measures may be found on the Board's website.

Authority: T.C.A. §§ 39-15-202, 39-17-1803, 39-17-1805, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-216, 68-11-268, 71-6-121, and 2016 Public Chapter 1003.

Rule 1200-08-10-.11 Records and Reports is amended by adding new paragraphs (7) and (8) which shall read:

(7) An ambulatory surgical treatment center in which more than fifty (50) surgical abortions are performed in a year shall make and maintain a record of the disposition of the aborted fetus or aborted fetal tissue as required in Tenn. Code Ann. § 68-3-305(a) and shall produce such records at the time of an inspection of the facility.

(8) An ambulatory surgical treatment center in which more than fifty (50) surgical abortions are performed in a year shall report sentinel events to Board staff.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-1-1004, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, and 68-11-216.

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

Amendments

Rule 1200-08-11-.01 Definitions is amended by deleting paragraphs (25), (32), (33), and (50) in their entirety and substituting instead the following language, so that as amended, the new paragraphs shall read:

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

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

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

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

Authority: T.C.A. §§ 4-5-202, 4-5-204, 39-11-106, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-216, 68-11-224, and 68-11-1802.

Rule 1200-08-11-.02 Licensing Procedures is amended by deleting subparagraph (4)(b) in its entirety and substituting instead the following language, so that as amended, the new part and subparagraph shall read:

(4) (b) If a licensee fails to renew its license prior to the date of its expiration but submits the renewal form and fee within sixty (60) days thereafter, the licensee may renew late by paying, in addition to the renewal fee, a late penalty of one hundred dollars ($100) per month for each month or

fraction of a month that renewal is late; provided that the late penalty shall not exceed twice the renewal fee.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-209(a)(1), 68-11-210, 68-11-216, Chapter 846 of the Public Acts of 2008, §1, T.C.A. §68-11-206(a)(5).

Rule 1200-08-11-.05 Admissions, Discharges and Transfers is amended by deleting paragraphs (7) and (8) and part (10)(h)1 in their entirety and substituting instead the following language, so that as amended the new paragraphs and part shall read:

(7) A home for the aged shall not admit or retain residents who pose a clearly documented danger to themselves or to other residents in the home. Persons in the early stages of Alzheimer's disease and related disorders may be admitted only after it has been determined by an interdisciplinary team that care can appropriately and safely be given in the facility. The interdisciplinary team must review such persons at least quarterly as to the appropriateness of placement in the facility. The interdisciplinary team shall consist of, at a minimum, a physician experienced in the treatment of Alzheimer's disease and related disorders, a social worker, a registered nurse, and a family member (or patient care advocate).

(8) Residents shall be capable of evacuating the home or facility within thirteen (13) minutes.

(10) (h) 1. Basic facts about the causes, progression and management of Alzheimer's disease and related disorders;

Authority: T.C.A. §§ 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-210, 68-11-257, and 71-6-121.

Rule 1200-08-11-.09 Infectious and Hazardous Waste is amended by deleting subparagraphs (4)(a) and (8)(a) in their entirety and substituting the following language, so that as amended, the new subparagraphs shall read:

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

(8) (a) A facility 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 disinfecting cycle must contain appropriate indicators to assure that conditions were met for proper sterilization or disinfection or 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.

Authority: T.C.A. §§ 4-5-202 through 4-5-206, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.

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

Amendments

Rule 1200-08-25-.06 Administration is amended by deleting parts (1)(a)2 and (5)(c)3 in their entirety and substituting instead the following language, so that as amended, the new parts shall read:

(1) (a) 2. If the licensee is a natural person, the licensee shall be at least twenty-one (21) 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.

The licensee shall also pass the Jurisprudence Examination prior to licensure. The Board Administrative staff shall forward the exam to the licensee. The examination must be completed and returned to the Board Administrative Office (Office of Health Care Facilities) before the expiration of ninety (90) days from the date of notification of eligibility, or the applicant shall forfeit eligibility for licensure and must repeat the licensure process.

The scope, format, and content of the examination shall be determined by the Board Administrative staff but limited to statutes and rules governing practices and facilities.

Correctly answering ninety percent (90%) of the examination questions shall constitute a passing score and successful completion of the jurisprudence exam. Applicants who fail to achieve a passing score on the examination may apply to retake it by written request to the Board Administrative Office and payment of the Jurisprudence Examination Fee.

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

Authority: T.C.A. §§ 39-17-1804, 39-17-1805, 68-3-511, 4-5-202, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-254, 68-11-268, and 71-6-121.

Rule 1200-08-25-.08 Admissions, Discharges, and Transfers is amended by deleting paragraph (8) and subparagraph (9)(c) in their entirety and substituting instead the following language, so that as amended the new paragraph and subparagraph shall read:

(8) Residents shall be capable of evacuating the home or facility within thirteen (13) minutes.

(9) (c) A current listing of the number of deaths and hospitalizations, with diagnoses that have occurred on the unit;

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

Rule 1200-08-25-.09 Building Standards is amended by deleting subparagraph (13)(f) in its entirety and substituting instead the following language, so that as amended, the new subparagraph shall read:

(13) (f) Ground-Fault Circuit Interrupters (GFCI) that are required in all wet areas, such as kitchens, laundries, janitor closets, bath and toilet rooms, etc., and within six (6) feet of any lavatory.

Authority: T.C.A. §§ 4-5-202, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-261.

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

(2) (b) Install necessary firefighting equipment;

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, and 68-11-213.

Rule 1200-08-25-.11 Infectious and Hazardous Waste is amended by deleting subparagraph (4)(a) in its entirety and substituting instead the following language, so that as amended, the new subparagraph shall read:

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

Authority: T.C.A. §§ 4-5-202, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.

I certify that the information included in this filing is an accurate and complete representation of the intent and scope of rulemaking proposed by the agency.

Date: 10/27/2021

Signature: Kyonzté Hughes-Toombs

Name of Officer: Kyonzté Hughes-Toombs

Title of Officer: Deputy General Counsel, Department of Health

Department of State Use Only

Filed with the Department of State on: 10/27/2021

Tre Hargett
Secretary of State

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

CHAPTER 1200-08-01
STANDARDS FOR HOSPITALS

TABLE OF CONTENTS

1200-08-01-.01 DEFINITIONS.

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

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

(a) How the deficiency will be corrected.

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

(c) The date the deficiency will be corrected.

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

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

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

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

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

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

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

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

(9) Central Services Department. A department within a healthcare facility that processes, issues, and controls medical supplies, devices and equipment, both sterile and nonsterile, for patient care areas of a healthcare institution.

(10) Central Services Technician. A person who decontaminates, inspects, assembles, packages, and sterilizes reusable medical instruments or devices in a healthcare institution, whether such person is employed by the healthcare institution or provides services pursuant to a contract with the healthcare institution.

(11~~9~~) Certified Master Social Worker. A person currently certified as such by the Tennessee Board of Social Worker Certification and Licensure.

(12~~0~~) Certified Nurse Practitioner. A person who is licensed as a registered nurse and has further been issued a certificate of fitness to prescribe and/or issue legend drugs by the Tennessee Board of Nursing.

(13~~1~~) Certified Registered Nurse Anesthetist. A registered nurse currently licensed by the Tennessee Board of Nursing who is currently certified as such by the American Association of Nurse Anesthetists.

(14~~2~~) Certified Respiratory Therapist. A person currently certified as such by the Tennessee Board of Medical Examiners' Council on Respiratory Care.

(15~~3~~) Certified Respiratory Therapy Technician. A person currently certified as such by the Tennessee Board of Medical Examiners' Council on Respiratory Care.

(16~~4~~) Clinical Laboratory Improvement Act (CLIA). The federal law requiring that clinical laboratories be approved by the U.S. Department of Health and Human Services, Health Care Financing Administration.

(17~~5~~) Collaborative Practice. The implementation of the collaborative plan that outlines procedures for consultation and collaboration with other health care professional, e.g., licensed physicians and mid-level practitioners.

(18~~6~~) Collaborative Plan. The formal written plan between the mid-level practitioners and a licensed physician.

(19~~7~~) Commissioner. The Commissioner of the Tennessee Department of Health or his or her authorized representative.

(20~~18~~) Competent. A patient who has capacity.

(21~~19~~) Critical Access Hospital. A hospital located in a rural area, certified by the Department as being a necessary provider of health care services to residents of the area, which makes available twenty-four (24) hour emergency care; is a designated provider in a rural health network; provides not more than twenty-five (25) acute care inpatient beds for providing inpatient care not to exceed an annual average of ninety-six (96) hours, and has a quality

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

assessment and performance improvement program and procedures for utilization review. If swing-bed approval has been granted, all twenty-five (25) beds can be used interchangeably for acute or Skilled Nursing Facility (SNF/swing-bed) level of care services.

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

(231) Department. The Tennessee Department of Health.

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

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

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

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

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

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

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

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

(3028) Emergency Responder. A paid or volunteer firefighter, law enforcement officer, or other public safety official or volunteer acting within the scope of his or her proper function under law or rendering emergency care at the scene of an emergency.

(3129) Graduate Registered Nurse Anesthetist. A registered nurse currently licensed in Tennessee who is a graduate of a nurse anesthesia educational program that is accredited by the American Association of Nurse Anesthetist's Council on Accreditation of Nurse Anesthesia Educational Programs and awaiting initial certification examination results, provided that initial certification is accomplished within eighteen (18) months of completion of an accredited nurse anesthesia educational program.

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

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

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

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

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

(364) Health Care Decision-maker. In the case of a patient who lacks capacity, the patient's health care decision-maker is one of the following: the patient's health care agent as specified in an advance directive, the patient's court-appointed guardian or conservator with health care decision-making authority, the patient's surrogate as determined pursuant to Rule 1200-08-01-.13 or T.C.A. § 33-3-220, the designated physician pursuant to these Rules or in the case of a minor child, the person having custody or legal guardianship.

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

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

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

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

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

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

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

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

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

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

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

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

(c) Chronic Disease Hospital. To be licensed as a chronic disease hospital, the institution shall be devoted exclusively to the diagnosis, treatment or care of persons needing medical, surgical or rehabilitative care for chronic or long-term illness, injury, or infirmity. The diagnosis, treatment or care shall be administered by or performed under the direction of persons currently licensed to practice the healing arts in the State of Tennessee. A chronic disease hospital shall meet the requirements for a general hospital except that obstetrical facilities are not required and, if the hospital provides no surgical services, an emergency department is not required.

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

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

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

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

(40~~38~~) Hospitalization. The reception and care of any person for a continuous period longer than twenty-four (24) hours, for the purpose of giving advice, diagnosis, nursing service or treatment bearing on the physical health of such persons, and maternity care involving labor and delivery for any period of time.

(41~~39~~) Incompetent. A patient who has been adjudicated incompetent by a court of competent jurisdiction and has not been restored to legal capacity.

(42~~0~~) Individual instruction. An individual's direction concerning a health care decision for the individual.

(43~~1~~) Infectious Waste. Solid or liquid wastes which contain pathogens with sufficient virulence and quantity such that exposure to the waste by a susceptible host could result in an infectious disease.

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

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

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

(a) An influx of mass casualties;

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

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

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

(475) Licensed health care professional. Any health care professional currently licensed by the State of Tennessee to practice within the scope of a regulated profession, such as a nurse practitioner, 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, podiatrist, psychologist, clinical social worker, speech language pathologist, and emergency service personnel.

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

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

(50)48) Life Threatening oOr Serious Injury. Injury requiring the patient to undergo significant additional diagnostic or treatment measures.

(5149) Medical Emergency. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part, which includes labor when delivery is imminent, when there is inadequate time to effect safe transfer to another hospital prior to delivery, or when a transfer may pose a threat to the health and safety of the patient or the unborn child.

(5250) Medical Record. Medical histories, records, reports, summaries, diagnoses, prognoses, records of treatment and medication ordered and given, entries, x-rays, radiology interpretations. and other written electronics, or graphic data prepared, kept, made or maintained in a facility that pertains to confinement or services rendered to patients admitted or receiving care.

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

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

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

(5~~3~~) Member of the Professional Medical Community. A professional employed by the hospital and on the premises at the time of a voluntary delivery.

(5~~4~~) Mid-Level Practitioner. Either a certified nurse practitioner or a physician assistant.

(5~~5~~) Misappropriation of Patient/Resident Property. The deliberate misplacement, exploitation or wrongful, temporary or permanent use of an individual's belongings or money without the individual's consent.

(5~~6~~) Neglect. The failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness; however, the withholding of authorization for or provision of medical care to any terminally ill person who has executed an irrevocable living will in accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of the living will, shall not be deemed "neglect" for purposes of these rules.

(5~~7~~) N.F.P.A. The National Fire Protection Association.

(60~~58~~) Nuclear Medicine Technologist. A person currently registered as such by the National Association for Nuclear Medicine Technology.

(61~~59~~) Nurse Midwife. A person currently licensed by the Tennessee Board of Nursing as a registered nurse (R.N.) and qualified to deliver midwifery services or certified by the American College of Nurse-Midwives.

(6~~0~~) Occupational Therapist. A person currently certified as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(6~~1~~) Occupational Therapy Assistant. A person currently certified as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(6~~2~~) Optometrist. A person currently licensed as such by the Tennessee Board of Optometry.

(6~~3~~) Patient. Includes but is not limited to any person who is suffering from an acute or chronic illness or injury or who is crippled, convalescent or infirm, or who is in need of obstetrical, surgical, medical, nursing or supervisory care.

(6~~4~~) Person. An individual, corporation, estate, trust, partnership, association, joint venture, government, governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

(6~~5~~) Personally Informing. A communication by any effective means from the patient directly to a health care provider.

(6~~6~~) Pharmacist. A person currently licensed as such by the Tennessee Board of Pharmacy.

(6~~7~~) Physical Therapist. A person currently certified as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(70~~68~~) Physical Therapy Assistant. A person currently certified as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(71~~69~~) Physician. An individual authorized to practice medicine or osteopathy under Tennessee Code Annotated, Title 63, Chapters 6 or 9.

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

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

(731) Physician Orders for Scope of Treatment or POST. Written orders that:

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

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

(c)

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

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

3. Specify both 1 and 2.

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

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

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

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

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

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

(8078) Registered Health Information Administrator (RHIA). A person currently registered as such by the American Health Information Management Association.

(8179) Registered Health Information Technician (RHIT). A person currently accredited as such by the American Health Information Management Association.

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

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

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

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

(85) Sentinel Event. An unexpected occurrence involving death or serious physical injury, or the risk thereof. Serious injury specifically includes loss of limb or function.

(863) Shall or Must. Compliance is mandatory.

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

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

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

(9087) Student. A person currently enrolled in a course of study that is approved by the appropriate licensing board.

(9188) Supervising Health Care Provider. The designated physician or, if there is no designated physician or the designated physician is not reasonably available, the health care provider who has undertaken primary responsibility for an individual's health care.

(9289) Surgical Technologist. A person who works under supervision to facilitate the safe and effective conduct of invasive surgical procedures. This individual is usually employed by a hospital, medical office, or surgical center and supervised during the surgical procedure according to institutional policy and procedure to assist in providing a safe operating room environment that maximizes patient safety by performing certain tasks including, but not limited to:

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

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

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

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

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

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

render any medical care on the grounds that the person does not have a medical need for hospital care.

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

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

(974) Voluntary Delivery. The action of a mother in leaving an unharmed infant aged seventy-two (72) hours or younger on the premises of a hospital with any hospital employee or member of the professional medical community without expressing any intention to return for such infant, and failing to visit or seek contact with such infant for a period of thirty (30) days thereafter.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 39-11-106, 68-11-202, 68-11-204, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-224, 68-11-255, 68-11-1802, 68-57-101, 68-57-102, and 68-57-105.* ***Administrative History:*** *Original rule certified June 7, 1974. Amendment filed April 3, 1974; effective May 3, 1974. Amendment filed November 30, 1984; effective December 30, 1984. Repeal and new rule filed May 22, 1986; effective June 21, 1986. Amendment filed April 26, 1996; effective July 8, 1996. Amendment filed November 30, 1999; effective February 6, 2000. Repeal, except for Paragraphs (1), (5), (8), (10), (11), (13), (16), (29), and (37) as promulgated February 6, 2000, and new rule filed March 18, 2000; effective May 30, 2000. Amendment filed April 17, 2000; effective July 1, 2000. Amendment filed September 17, 2002; effective December 1, 2002. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed April 28, 2003; effective July 12, 2003. Amendment filed August 27, 2004; effective November 10, 2004. Amendments filed September 6, 2005; effective November 20, 2005. Amendment filed February 23, 2006; effective May 9, 2006. Amendment filed February 7, 2007; effective April 23, 2007. Amendment filed February 22, 2010; effective May 23, 2010. Amendments filed March 18, 2010; effective June 16, 2010. Amendment filed January 3, 2012; effective April 2, 2012. Amendment filed March 27, 2015; effective June 25, 2015. Amendment filed April 25, 2016; effective July 24, 2016. Amendments filed July 10, 2018; effective October 8, 2018.*

1200-08-01-.02 LICENSING PROCEDURES.

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

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

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

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

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

(Rule 1200-08-01-.02, continued)

68-11-206(1), or as later amended, and of all information required by the Commissioner.

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

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

(f) The applicant shall allow the hospital to be inspected by a Department surveyor. In the event that deficiencies are noted, the applicant shall submit a plan of corrective action to the Board that must be accepted by the Board. Once the deficiencies have been corrected, then the Board shall consider the application for licensure.

(3) A proposed change of ownership, including a change in a controlling interest, must be reported to the department a minimum of thirty (30) days prior to the change. A new application and fee must be received by the department before the license may be issued.

(a) For the purposes of licensing, the licensee of a hospital has the ultimate responsibility for the operation of the facility, including the final authority to make or control operational decisions and legal responsibility for the business management. A change of ownership occurs whenever this ultimate legal authority for the responsibility of the hospital's operation is transferred.

(b) A change of ownership occurs whenever there is a change in the legal structure by which the hospital is owned and operated.

(c) Transactions constituting a change of ownership include, but are not limited to, the following:

1. Transfer of the facility's legal title;

2. Lease of the facility's operations;

3. Dissolution of any partnership that owns, or owns a controlling interest in, the facility;

4. One partnership is replaced by another through the removal, addition or substitution of a partner;

5. Removal of the general partner or general partners, if the facility is owned by a limited partnership;

6. Merger of a facility owner (a corporation) into another corporation where, after the merger, the owner's shares of capital stock are cancelled;

7. The consolidation of a corporate facility 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;

(Rule 1200-08-01-.02, continued)

2. Two (2) or more corporations merge and the originally-licensed corporation survives;

3. Changes in the membership of a non-profit corporation;

4. Transfers between departments of the same level of government; or,

5. Corporate stock transfers or sales, even when a controlling interest.

(e) Management agreements are generally not changes of ownership if the owner continues to retain ultimate authority for the operation of the facility. However, if the ultimate authority is surrendered and transferred from the owner to a new manager, then a change of ownership has occurred.

(f) Sale/lease-back agreements shall not be treated as changes in ownership if the lease involves the facility's entire real and personal property and if the identity of the leasee, who shall continue the operation, retains the exact same legal form as the former owner.

(4) Each hospital, except those operated by the U.S. Government or the State of Tennessee, making application for license under this chapter shall pay annually to the department a fee based on the number of hospital beds, as follows:

(a)	Less than 25 beds	$ 1,040.00
(b)	25 to 49 beds, inclusive	$ 1,300.00
(c)	50 to 74 beds, inclusive	$ 1,560.00
(d)	75 to 99 beds, inclusive	$ 1,820.00
(e)	100 to 124 beds, inclusive	$ 2,080.00
(f)	125 to 149 beds, inclusive	$ 2,340.00
(g)	150 to 174 beds, inclusive	$ 2,600.00
(h)	175 to 199 beds, inclusive	$ 2,860.00

For hospitals of two hundred (200) beds or more the fee shall be two thousand eight hundred and sixty dollars ($2,860.00) 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.

(5) Renewal.

(a) In order to renew a license, each hospital shall submit to periodic inspections by Department surveyors for compliance with these rules. If deficiencies are noted, the licensee shall submit an acceptable plan of corrective action and shall remedy the deficiencies. In addition, each licensee shall submit a renewal form approved by the board and applicable renewal fee prior to the expiration date of the license.

(b) If a licensee fails to renew its license prior to the date of its expiration but submits the renewal form and fee within sixty (60) days thereafter, the licensee may renew late by paying, in addition to the renewal fee, a late penalty of one hundred dollars ($100) per

(Rule 1200-08-01-.02, continued)

month for each month or fraction of a month that renewal is late; provided that the late penalty shall not exceed twice the renewal fee.

(c) In the event that a licensee fails to renew its license within the sixty (60) day grace period following the license expiration date, then the licensee shall reapply for a license by submitting the following to the Board office:

1. A completed application for licensure;

2. The license fee provided in rule 1200-08-01-.02(4); and

3. Any other information required by the Health Services and Development Agency.

(d) Upon reapplication, the licensee shall submit to an inspection of the hospital by Department of Health surveyors.

Authority: *T.C.A. §§ 4-5-201, 4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-206(a)(5), 68-11-209, 68-11-209(a)(1), 68-11-210, 68-11-216, and Chapter 846 of the Public Acts of 2008, § 1.* ***Administrative History:*** *Original rule certified June 7, 1974. Repeal and new rule filed May 22, 1986; effective June 21, 1986. Amendment filed January 16, 1992; effective March 2, 1992. Repeal and new rule filed March 18, 2000; effective May 30, 2000. Amendment filed December 2, 2003; effective February 15, 2004. Amendment filed January 19, 2007; effective April 4, 2007. Public necessity rules filed April 29, 2009; effective through October 11, 2009. Emergency rules filed October 9, 2009; effective through April 7, 2010. Amendments filed September 24, 2009; effective December 23, 2009. Amendment filed December 16, 2013; effective March 16, 2014. Amendments filed March 21, 2018; to have been effective June 19, 2018. However, on May 24, 2018, the Government Operations Committee filed a 5-day stay; new effective date June 24, 2018.*

1200-08-01-.03 DISCIPLINARY PROCEDURES.

(1) The board may suspend or revoke a license for:

(a) Violation of federal or state statutes;

(b) Violation of the rules as set forth in this chapter;

(c) Permitting, aiding or abetting the commission of any illegal act in the hospital;

(d) Conduct or practice found by the board to be detrimental to the health, safety, or welfare of the patients of the hospital; and

(e) Failure to renew license.

(2) The board may consider all factors which it deems relevant, including but not limited to the following when determining sanctions:

(a) The degree of sanctions necessary to ensure immediate and continued compliance;

(b) The character and degree of impact of the violation on the health, safety and welfare of the patients in the facility;

(c) The conduct of the facility in taking all feasible steps or procedures necessary or appropriate to comply or correct the violation; and

(d) Any prior violations by the facility of statutes, regulations or orders of the board.

(Rule 1200-08-01-.03, continued)

(3) Inappropriate transfers are prohibited and violation of the transfer provisions shall be deemed sufficient grounds to suspend or revoke a hospital's license.

(4) When a hospital is found by the department to have committed a violation of this chapter, the department will issue to the facility a statement of deficiencies. Within ten (10) days of the receipt of the deficiencies, the hospital must return a plan of correction indicating 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.

(5) Either failure to submit a plan of correction in a timely manner or a finding by the department that the plan of correction is unacceptable shall subject the hospital's license to possible disciplinary action.

(6) Any licensee or applicant for a license, aggrieved by a decision or action of the department or board, pursuant to this chapter, may request a hearing before the board. The proceedings and judicial review of the board's decision shall be in accordance with the Uniform Procedures Act, T.C.A. §§ 4-5-101, et seq.

(7) Reconsideration and Stays. The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-04-01-.18 regarding petitions for reconsiderations and stays in that case.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 4-5-219, 4-5-312, 4-5-316, 4-5-317, 68-11-202, 68-11-204, 68-11-206, 68-11-208, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule certified June 7, 1974. Amendment filed April 3, 1974; effective May 3, 1974. Amendment filed February 26, 1985; effective March 28, 1985. Repeal and new rule filed May 22, 1986; effective June 21, 1986. Amendment filed December 30, 1986; effective February 13, 1987. Repeal and new rule filed March 18, 2000; effective May 30, 2000. Amendment filed March 1, 2007; effective May 15, 2007.*

1200-08-01-.04 ADMINISTRATION.

(1) The hospital must have an effective governing body legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this chapter.

(2) The governing body shall appoint a chief executive officer or administrator who is responsible for managing the hospital. The chief executive officer or administrator shall designate an individual to act for him or her in his or her absence, in order to provide the hospital with administrative direction at all times.

(3) When licensure is applicable for a particular job, the number and renewal number of the current license or a copy of the internet verification of such license must be maintained in personnel. Each personnel file shall contain accurate information as to the education, training, experience and personnel background of the employee. Adequate medical screenings to exclude communicable disease shall be required of each employee.

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

(4) Whenever the rules and regulations of this chapter require that a licensee develop a written policy, plan, procedure, technique, or system concerning a subject, the licensee shall develop the required policy, maintain it and adhere to its provisions. A hospital which violates a required policy also violates the rule and regulation establishing the requirement.

(5) Policies and procedures shall be consistent with professionally recognized standards of practice.

(6) No hospital shall retaliate against or, in any manner, discriminate against any person because of a complaint made in good faith and without malice to the board, the department, the Adult Protective Services, or the Comptroller of the State Treasury. A hospital shall neither retaliate, nor discriminate, because of information lawfully provided to these authorities, because of a person's cooperation with them, or because a person is subpoenaed to testify at a hearing involving one of these authorities.

(7) The hospital shall ensure a framework for addressing issues related to care at the end of life.

(8) The hospital shall provide a process that assesses pain in all patients. There shall be an appropriate and effective pain management program.

(9) Critical Access Hospital.

(a) The facility shall enter into agreements with one or more hospitals participating in the Medicare/Medicaid programs to provide services which the Critical Access Hospital is unable to provide.

(b) When there are no inpatients, the facility is not required to be staffed by licensed medical professionals, but must maintain a receptionist or other staff person on duty to provide emergency communication access. The hospital shall provide an effective system to ensure that a physician or a mid-level practitioner with training and experience in emergency care is on call and immediately available by telephone or radio and available on site within thirty (30) minutes, twenty-four (24) hours a day.

(10) All health care facilities licensed pursuant to T.C.A. §§ 68-11-201, et seq. shall post the following in the main public entrance:

(a) Contact information including statewide toll-free number of the division of adult protective services, and the number for the local district attorney's office;

(b) A statement that a person of advanced age who may be the victim of abuse, neglect, or exploitation may seek assistance or file a complaint with the division concerning abuse, neglect and exploitation; and

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

Postings of (a) and (b) shall be on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height.

(11) "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.

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

(12) Hospice services may be provided in an area designated by a hospital for exclusive use by a home care organization certified as a hospice provider to provide care at the hospice inpatient or respite level of care in accordance with the hospice's Medicare certification. Admission to the hospital is not required in order for a patient to receive such hospice services, regardless of the patient's length of stay. The designation by a hospital of a portion of its facility for exclusive use by a home care organization to provide hospice services to its patients shall not:

(a) Alter the license to bed complement of such hospital, or

(b) Result in the establishment of a residential hospice.

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

(14) Informed Consent

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(16) Anyone arriving at a hospital and/or the emergency department of a hospital requesting or requiring an examination or treatment for a medical condition must be provided an appropriate medical screening examination within the capability of the hospital's staff to determine whether or not a medical emergency exists.

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

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

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

(b) Initiating control of hemorrhage;

(c) Stabilizing and splinting the spine or fractures;

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

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

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

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

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

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

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

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

1. The medical necessity of the movement;

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

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

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

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

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

(20) An appropriate transfer includes:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(24) Infant Abandonment.

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

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

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

2. Is left in an unharmed condition; and

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

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

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

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

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

(25) Caregiver

(a) The hospital shall give a patient admitted to the hospital the opportunity to designate a caregiver who will assist the patient with continuing care after discharge from the hospital.

1. Caregiver means any individual designated as a caregiver by a patient who provides after-care assistance to a patient in a private residence. The term includes, but is not limited to, a relative, spouse, partner, friend or neighbor who has a significant relationship with the patient.

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

2. The hospital shall document the designated caregiver in the patient record and include contact information; and

3. If the patient declines to designate a caregiver, the hospital shall document the patient's choice in the medical record.

(b) The hospital shall notify the designated caregiver as soon as practicable before the patient is discharged back to a private residence.

(c) If the hospital is unable to contact the designated caregiver when changes occur, the lack of contact shall not interfere with, delay or otherwise affect the medical care provided to the patient or the transfer or discharge of the patient. Nothing in this paragraph shall interfere with, delay or otherwise affect the medical care provided to the patient or the transfer or discharge of the patient.

(d) The hospital shall make reasonable efforts to contact the designated caregiver and document those efforts in the patient record, to include dates and times attempted.

(e) The patient may give written consent to allow the hospital to release medical information to the designated caregiver, pursuant to the hospital's established procedures for the release of personal health information.

(f) Prior to the patient being discharged, the hospital shall provide discharge instructions for continuing care needs to the patient and designated caregiver, which shall include:

1. The name and contact information of the designated caregiver and relation to the patient;

2. A description of continuing care tasks that the patient requires, communicated in a culturally competent manner; and

3. Contact information for any health care, community resources, and long-term services and supports necessary to successfully carry out the patient's discharge instructions.

(g) Prior to the patient being discharged, the hospital shall provide the designated caregiver with an opportunity for instruction in continuing care tasks outlined in the discharge instructions, which shall include:

1. Demonstration of the continuing care tasks by hospital personnel; and

2. Opportunity for the patient and designated caregiver to ask questions and receive answers regarding the continuing care tasks; and

3. Education and counseling about medications, including dosing and proper use of delivery devices.

(h) The hospital shall document the instruction given to the patient and designated caregiver in the patient record, to include the date, time and contents of the instructions.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, and 68-11-255.* ***Administrative History:*** *Original rule filed March 18, 2000; effective May 30, 2000. Amendment filed April 17, 2000; effective July 1, 2000. Amendment filed September 17, 2002; effective December 1, 2002. Amendments filed July 10, 2018; effective October 8, 2018. Amendments filed January 7, 2019; to have*

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become effective April 7, 2019. However, the Government Operations Committee filed a 60-day stay of the effective date of the rules; new effective date June 6, 2019.

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

(1) Performance Improvement.

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

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

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

2. Nosocomial infections and medication therapy are evaluated;

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

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

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

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

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

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

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

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

(2) Medical Staff.

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

(b) The hospital and medical staff bylaws shall contain procedures, governing decisions or recommendations of appropriate authorities concerning the granting, revocation,

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

suspension, and renewal of medical staff appointments, reappointments, and/or delineation of privileges. At a minimum, such procedures shall include the following elements: A procedure for appeal and hearing by the governing body or other designated committee if the applicant or medical staff feels the decision is unfair or wrong.

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

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

1. Be approved by the governing body;

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

3. Describe the organization of the medical staff;

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

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

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

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

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

1. Periodically conduct appraisals of its members;

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

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

(g) The medical staff must be structured in a manner approved by the hospital or its governing body, well organized, and accountable to the hospital for the quality of the

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

medical care provided to the patient. Disciplinary action involving medical staff taken by the hospital shall be reported to the appropriate licensing board or professional society.

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

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

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

(3) Infection Control.

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

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

1. Written infection control policies;

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

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

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

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

(iii) Chlorhexidine skin antisepsis;

(iv) Optimal site selection;

(v) Daily review of line necessity; and

(vi) Development and utilization of a procedure checklist;

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

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

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

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

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

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

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

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

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

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

2. A signed declination statement on record from all who refuse the influenza vaccination for reasons other than medical contraindications (a sample form is available at https://www.tn.gov/content/dam/tn/health/documents/SampleIndividualFluForm.pdf);

3. Education of all employees about the following:

(i) Flu vaccination,

(ii) Non-vaccine control measures, and

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

(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 as declared by the Commissioner or the Commissioner's designee.

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

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

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

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

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

4. Health care worker education programs which may include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(l) No person shall practice as a central service technician unless the person:

1. Has successfully passed a nationally accredited central service exam for central service technicians and holds and maintains one (1) of the following credentials:

(i) A certified registered central service technician credential administered by the International Association of Healthcare Central Service Material Management; or

(ii) A certified sterile processing and distribution technician credential administered by the Certification Board for Sterile Processing and Distribution, Inc.; or

(iii) Was employed or otherwise contracted for services as a central service technician in a healthcare institution before January 1, 2017; or

(iv) Obtains a certified registered central service technician credential administered by the International Association of Healthcare Central Service Material Management or the Certification Board for Sterile Processing and Distribution, Inc., not later than two (2) years after the person's date of hire or contracting for services with a healthcare institution.

2. A central service technician shall complete a minimum of ten (10) hours of continuing education within a calendar year. The continuing education shall be in areas related to the functions of a central service technician. Continuing education shall be maintained in the employee's personnel file. National certification shall satisfy this requirement.

3. Nothing in this section shall prohibit the following persons from performing the tasks or functions of a central service technician:

(i) A healthcare provider operating within the scope of practice for that provider established pursuant to title 63;

(ii) A surgical technologist operating within the scope of practice established

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by § 68-57-105;

(iii) A student or intern performing the functions of a central service technician under the direct supervision of a healthcare provider as part of the student's or intern's training or internship; or

(iv) A person who does not work in a central service department in a healthcare facility, but who has been specially trained and determined competent, based on standards set by a healthcare institution's infection prevention or control committee, acting in consultation with a central service technician certified in accordance with subsection (b), to decontaminate or sterilize reusable medical equipment, instruments, or devices, in a manner that meets applicable manufacturer's instructions and standards.

4. A healthcare institution shall retain a list of persons determined to be competent under subsection (d). The list shall include job titles for such persons. A person determined to be competent pursuant to subsection (d) shall annually complete a minimum of ten (10) hours of continuing education in areas related to infection control and the decontamination and sterilization of reusable medical equipment, instruments and devices.

5. Any healthcare institution that employs or contracts with a central service technician shall submit to the department of health, upon request, including, but not limited to, during an inspection performed pursuant to this part, documentation demonstrating that the central service technician complies with the requirements of this section.

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

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

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

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

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

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

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

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

(pe) Laundry facilities located in the hospital shall:

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

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

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

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

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

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

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

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

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

5. Conducting periodic inspections of any contract laundry facility.

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

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

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

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

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

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

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

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

(4) Nursing Services.

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

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

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

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

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

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

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

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

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

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

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

3. The nurse is licensed by the state; and

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

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

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

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

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

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

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

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

(5) Medical Records.

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

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

(c) The organization of the medical record service must be appropriate to the scope and complexity of the services performed. The hospital must employ adequate personnel to ensure prompt completion, filing and retrieval of records.

(d) The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurate, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record

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

maintenance that ensures the integrity of the authentication and protects the security of all record entries.

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

(f) When a hospital closes with no plans of reopening, an authorized representative of the hospital may request final storage or disposition of the hospital's medical records by the department. Upon transfer to the department, the hospital relinquishes all control over final storage of the records in the files of the Tennessee Department of Finance and Administration and the files shall become property of the State of Tennessee.

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

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

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

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

(k) All records must document the following:

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

2. Admitting diagnosis;

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

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

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

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

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

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

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

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

(6) Pharmaceutical Services.

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

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

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

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

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

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

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

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

(7) Radiologic Services.

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

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

(c) Patients, employees and the general public shall be provided protection from radiation in accordance with "State Regulations for Protection Against Radiation". All radiation producing equipment shall be registered and all radioactive material shall be licensed

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by the Division of Radiological Health of the Tennessee Department of Environment and Conservation.

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

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

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

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

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

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

(8) Laboratory Services.

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

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

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

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

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

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

(9) Food and Dietetic Services.

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

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

outside contract is utilized for management of its dietary services, the hospital shall designate a full-time employee to be responsible for the overall management of the services.

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

1. A qualified dietitian; or,

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

3. An individual who has successfully completed in-person or online coursework that provided ninety (90) or more hours of classroom instruction in food service supervision. If the course has not been completed, this person shall be enrolled in a course and making satisfactory progress for completion within the time limit specified by the course requirement; or,

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

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

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

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

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

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

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

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

(f) Education programs, including orientation, on-the-job training, inservice education, and continuing education programs shall be offered to dietetic services personnel on a

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

regular basis. Programs shall include instruction in personal hygiene, proper inspection, handling, preparation and serving of food and equipment.

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

(h) All food shall be from sources approved or considered satisfactory by the department and shall be clean, wholesome, free from spoilage, free from adulteration and misbranding and safe for human consumption. No food which has been processed in a place other than a commercial food processing establishment shall be used.

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

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

(10) Critical Access Hospital.

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

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

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

(d) A physician on staff shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Microscopic examinations of urine sediment;

3. Hemoglobin or hematocrit;

4. Blood sugar;

5. Gram stain;

6. Examination of stool specimens for occult blood;

7. Pregnancy test;

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

9. Sediment rate; and,

10. CBC.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-3-511, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed March 18, 2000; effective May 30, 2000. Amendment filed December 2, 2003; effective February 15, 2004. Amendment filed May 24, 2004;*

(Rule 1200-08-01-.06, continued)
effective August 7, 2004. Amendment filed September 6, 2005; effective November 20, 2005. Amendment filed July 18, 2007; effective October 1, 2007. Amendment filed December 23, 2009; effective March 23, 2010. Amendment filed March 18, 2010; effective June 16, 2010. Amendment filed December 16, 2013; effective March 16, 2014. Amendments filed July 18, 2016; effective October 16, 2016. Amendments filed July 10, 2018; effective October 8, 2018.

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

(1) Surgical Services.

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

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

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

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

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

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

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

(h) Surgical technologists must:

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

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

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

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

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

(i) A hospital can petition the director of health care facilities of the department for a waiver from the provisions of 1200-08-01-.07(1)(h) if they are unable to employ a sufficient number of surgical technologists who meet the requirements. The facility shall demonstrate to the director that a diligent and thorough effort has been made to employ surgical technologist who meet the requirements. The director shall refuse to grant a waiver upon finding that a diligent and thorough effort has not been made. A waiver shall exempt a facility from meeting the requirements for not more than nine (9) months. Additional waivers may be granted, but all exemptions greater than twelve (12) months shall be approved by the Board for Licensing Health Care Facilities.

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

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

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

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

1. Call-in system;

2. Cardiac monitor;

3. Resuscitator;

4. Defibrillator;

5. Aspirator; and

6. Tracheotomy set.

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

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

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

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

(2) Anesthesia Services.

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

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

1. A qualified anesthesiologist;

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

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

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

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

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

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

2. An intraoperative anesthesia record;

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

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

(3) Nuclear Medicine Services.

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

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

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

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

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

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

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

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

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

1. Maintained in safe operating condition; and,

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

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

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

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

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

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

(4) Outpatient Services.

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

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

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

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

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

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

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

3. Any duly licensed out of state health care professional as listed in T.C.A. § 68-29-121 who is authorized by his or her state board to order outpatient laboratory

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

testing in hospitals for individuals with whom that practitioner has an existing face-to-face patient relationship as outlined in rule 0880-02-.14(7)(a)1., 2., and 3.

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

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

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

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

(5) Emergency Services.

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

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

1. The hospital's physical geographic boundaries; or

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

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

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

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

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

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

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

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

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

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

(h) Legend drugs in emergency rooms shall be stored in locked cabinets, except as otherwise provided for emergency drugs by the written policies and procedures of the hospital. Discharge medications may be dispensed to out-patients upon written physician orders provided that they have been packaged in containers by the pharmacist in amounts not to exceed twelve (12) hours dosage and labeled in accordance with Pharmacy Board rules.

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

1. Identification data;

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

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

4. Significant physical findings;

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

6. Treatment rendered;

7. Condition of the patient on discharge or transfer;

8. Diagnosis on discharge;

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

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

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

(6) Rehabilitation Services.

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

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

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

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

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

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

(7) Obstetrical Services.

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

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

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

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

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

1. The name of the patient;

2. Her maiden name;

3. Date of delivery;

4. Sex of infant;

5. Name of physician;

6. Names of persons assisting;

7. What complications, if any, occurred;

8. Type of anesthesia used;

9. Name of person administering anesthesia; and

10. Other persons present.

(8) Pediatric Services.

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

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

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

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

(9) Respiratory Care Services.

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

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

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

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

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

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

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

(10) Social Work Services.

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

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

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

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

(11) Psychiatric Services.

(a) If a hospital provides psychiatric services, a psychiatric unit devoted exclusively for the care and treatment of psychiatric patients and professional personnel qualified in the diagnosis and treatment of patients with psychiatric illnesses shall be provided. Adequate protection shall be provided for patients and the staff against any physical injury resulting from a patient becoming violent. A psychiatric unit shall meet the

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

requirements as needed to care for patients admitted, either through direct care or by contractual arrangements.

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

(12) Alcohol and Drug Services.

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

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

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

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-3-511, 68-11-202, 68-11-204, 68-11-209, 68-57-101, 68-57-102, 68-57-104, and 68-57-105.* ***Administrative History:*** *Original rule filed March 18, 2000; effective May 30, 2000. Amendment filed April 17, 2000; effective July 1, 2000. Amendment filed June 12, 2003; effective August 26, 2003. Amendment filed July 27, 2005; effective October 10, 2005. Amendment filed February 23, 2006; effective May 9, 2006. Amendment filed February 23, 2007; effective May 9, 2007. Amendment filed February 22, 2010; effective May 23, 2010. Amendment filed January 3, 2012; effective April 2, 2012. Amendment filed March 27, 2015; effective June 25, 2015. Amendments filed July 10, 2018; effective October 8, 2018.*

1200-08-01-.08 BUILDING STANDARDS.

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

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

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

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

(4) A licensed contractor shall perform all new construction and renovations to hospitals, other than minor alterations not affecting fire and life safety or functional issues, in accordance with the specific requirements of these regulations governing new construction in hospitals, including the submission of phased construction plans and the final drawings and the specifications to each.

(5) No new hospital shall be constructed, nor shall major alterations be made to an existing hospital without prior written approval of the department, and unless in accordance with plans and specifications approved in advance by the department. Before any new hospital is licensed or before any alteration or expansion of a licensed hospital 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 where applicable:

(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;

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

(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 where applicable:

(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 where applicable:

(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 where applicable:

(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;

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

(c) An electrical system that complies with applicable codes;

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

(e) Circuit breakers that are properly labeled; and

(f) Ground-Fault Circuit Interrupters (GFCI) that are required in all wet areas, such as kitchens, laundries, janitor closets, bath and toilet rooms, etc, and within six (6) feet of any lavatory.

(14) The electrical drawings shall not include knob and tube wiring, shall not include electrical cords that have splices, and shall not show that the electrical system is overloaded.

(15) In all new facilities or renovations to existing electrical systems, the installation must be approved by an inspector or agency authorized by the State Fire Marshal.

(16) Sprinkler drawings shall include where applicable:

(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.

(17) 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 hospital 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.

(18) It shall be demonstrated through the submission of plans and specifications that in each hospital:

(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) Rooms and areas containing radiation producing machines or radioactive material must have primary and/or secondary barriers to assure compliance with Regulations for Protection Against Radiation and security for materials. Radiation material shall be

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

required to be stored and security must be provided in accordance with federal and state regulations to prevent exposure of the material to theft or tampering.

(19) When constructing new facilities or during major renovations to the operating suites, the hospital shall ensure that male and female physicians and staff have equitable proportional locker facilities including equal equipment, and similar amenities, with equal access to uniforms. Existing hospitals shall strive to have equitable male and female facilities. If physical changes are required, the additional areas shall maintain the flow and divisions in the sterile environments.

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

(21) In the event submitted materials do not appear to satisfactorily comply with 1200-08-01-.08(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.

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

(23) 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 1200-08-01-.08(2). 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.

(24) Prior to final inspection a CD Rom disc, in TIF or PDF format, of the final approved plans including all shop drawings, sprinkler, calculations, hood and duct, addenda, specifications, etc., shall be submitted to the department.

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

(a) Fire alarms;

(b) Generators (if applicable); and

(c) Medical gas alarms (if applicable).

(26) Each hospital shall ensure that an emergency keyed lock box is installed next to each bank of functioning elevators located on the main level. Such lock boxes shall be permanently mounted seventy-two inches (72") from the floor to the center of the box, be operable by a universal key no matter where such box is located, and shall contain only fire service keys and drop keys to the appropriate elevators.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-216, and 68-11-261.* ***Administrative History:*** *Original rule filed March 18, 2000; effective May 30, 2000. Amendment filed February 18, 2003; effective May 4, 2003. Repeal and new rule filed September 6, 2005; effective November 20, 2005. Amendment filed February 23, 2007; effective May 9, 2007. Repeal and new rule filed December 20, 2011; effective March 19, 2012. Amendment filed January 21, 2016; effective April 20, 2016.*

1200-08-01-.09 LIFE SAFETY.

(1) Any hospital which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.

(2) The hospital shall provide fire protection by the elimination of fire hazards, by the installation of necessary fire fighting equipment and by the adoption of a written fire control plan. Fire drills shall be held at least quarterly for each work shift for hospital personnel in each separate patient-occupied hospital building. There shall be a written report documenting the evaluation of each drill and the action recommended or taken for any deficiencies found. Records which document and evaluate these drills must be maintained for at least three (3) years. All fires which result in a response by the local fire department shall be reported to the department within seven (7) days. The report shall contain sufficient information to ascertain the nature and location of the fire, its probable cause and any injuries incurred by any person or persons as a result of the fire. Initial reports by the facility may omit the name(s) of patient(s) and parties involved, however, should the department find the identities of such persons to be necessary to an investigation, the facility shall provide such information.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed March 18, 2000; effective May 30, 2000. Amendments filed September 6, 2005; effective November 20, 2005.*

1200-08-01-.10 INFECTIOUS WASTE AND HAZARDOUS WASTE.

(1) Each hospital must develop, maintain and implement written policies and procedures for the definition and handling of its infectious and hazardous wastes. These policies and procedures must comply with the standards of this section and all other applicable state and federal regulations.

(2) The following waste shall be considered to be infectious waste:

(a) Waste contaminated by patients 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, waste from the production of biologicals, discarded live and attenuated vaccines, 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 patient care or which have come into contact with infectious agents during use in medical, research, or industrial laboratories;

(f) Contaminated carcasses, body parts, and bedding of animals that were exposed to pathogens in research, in the production of biologicals, or in the in vivo testing of pharmaceuticals; and

(Rule 1200-08-01-.10, continued)

(g) Other waste determined to be infectious by the facility 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 facility.

(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 storage, 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 or stored 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 disinfected each time they are emptied, unless the surfaces of the containers have been completely protected from contamination by disposable fluid resistant liners or other devices removed with the waste; and

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

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

(a) Infectious waste must not be compacted or ground (i.e., in a mechanical grinder) prior to treatment, except that pathological waste may be ground prior to disposal; and

(b) 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.

(c) Outside containers should have a biohazard label conspicuously identified.

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

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

(Rule 1200-08-01-.10, continued)

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

(c) Sanitize all contaminated equipment and surfaces appropriately. Written policies and procedure must specify how this will be done; and

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

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

(a) A facility 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 are 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 conditions were met for proper sterilization or disinfection of materials included in the cycle, and records kept. Proper operation of such devices must be verified at least monthly, and records of these monthly checks 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 a 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) The facility 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) The facility 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 facility 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 facility must notify in writing all public health agencies with jurisdiction that the location is being used for management of the facility'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 subparagraph. Any other human limbs and recognizable organs must be incinerated or discharged (following grinding) to the sewer.

(11) All garbage, trash and other non-infectious waste shall be stored, transported, 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

(Rule 1200-08-01-.10, continued)

shall be water tight, constructed of easily-cleanable material and shall be kept on elevated platforms.

Authority: *T.C.A. §§ 4-5-202, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed March 18, 2000; effective May 30, 2000.*

1200-08-01-.11 RECORDS AND REPORTS.

(1) A report listing all births, deaths and reportable fetal deaths which have occurred in the hospital shall be filed with the local registrar in the county where the institution is located or as otherwise directed by the State Registrar. The report shall be filed on the third (3rd) day of the month after the month in which the event occurred on a form or in a format prescribed by the State Registrar. If no birth, death or reportable fetal death occurred in the hospital, the report should be filed to indicate that fact.

(2) A Certificate of Live Birth shall be prepared for each live birth which occurred in the hospital or en route thereto on a form or in a format prescribed by the State Registrar and submitted to the State Registrar within ten (10) days of the birth.

(3) Immediately before or after the birth of a child to an unmarried woman in the facility, an authorized representative of the facility shall provide the mother, and if present, the biological father:

(a) Written information concerning the benefits, rights and responsibilities of establishing paternity for the child, as provided to the hospital by the Tennessee Department of Human Services;

(b) An Acknowledgment of Paternity Form provided by the department; and

(c) The opportunity to complete and submit to the hospital the Acknowledgment Form. The original, signed Acknowledgment of Paternity Form shall be submitted with the original birth certificate as directed by the State Registrar. A duplicate original Acknowledgment of Paternity Form shall be filed with the juvenile court of the county where the mother resides. Copies of the acknowledgment form shall be provided to the mother and the father of the child.

(4) A report of fetal death shall be completed by the hospital for each dead fetus delivered where the fetus weighs three hundred fifty (350) grams or more, or in the absence of weight, is of twenty (20) completed weeks of gestation or more. The report shall be in a form or format approved by the State Registrar and shall be submitted to the department's Office of Vital Records within ten (10) days of the delivery.

(5) Hospitals shall submit their Joint Annual Report data within one hundred and fifty (150) days after the end of each hospital's fiscal year and within one hundred and five (105) days after closure or a change in ownership. Hospitals shall also submit to the department, at the same time the hospital sends the signed paper copy of the report, a notarized statement from the hospital's chief financial officer stating that the financial data reported on the Joint Annual Report is consistent with the audited financials for the hospital for that reporting year. The notarized statement shall also be attested to by the chief executive officer of the submitting hospital.

(6) Hospitals that fail to file their joint annual report timely or that file a joint annual report that does not include all of the required data elements or includes data that does not pass the department's edits shall receive a deficiency from the department. Within ten (10) calendar days, the hospital shall be required to return a plan of correction indicating: how the deficiency will be corrected; the date upon which each deficiency will be corrected; what

(Rule 1200-08-01-.11, continued)

measures or systemic changes will be put in place to ensure that the deficient practice does not recur; and how the corrective action will be monitored to ensure the deficient practice does not recur. Either failure to submit a plan of correction in a timely manner or a finding by the department that the plan of correction is unacceptable shall subject the hospital's license to possible disciplinary action.

(7) The hospital shall report each case of communicable disease to the local county health officer in the manner provided by existing regulations. Repeated failure to report communicable diseases shall be cause for a revocation of a hospital license.

(8) The hospital shall report all incidents of abuse, neglect, and misappropriation to the Department of Health in accordance with T.C.A. § 68-11-211.

(9) The hospital shall report the following incidents to the Department of Health in accordance with T.C.A. § 68-11-211.

(a) Strike by staff at the facility;

(b) External disasters impacting the facility;

(c) Disruption of any service vital to the continued safe operation of the hospital or to the health and safety of its patients and personnel; and

(d) Fires at the hospital that disrupt the provision of patient care services or cause harm to the patients or staff, or that are reported by the facility to any entity, including but not limited to a fire department charged with preventing fires.

(10) The hospital shall report information contained in the medical records of patients who have cancer or pre-cancerous or tumorous diseases as provided by existing regulations. These reports shall be sent to the Cancer Reporting System of the department on a quarterly schedule no later than six (6) months after the date of the diagnosis or treatment.

(11) The hospital shall report, at least quarterly to the department, claims data on the UB-92 form or its successor for all discharges from the facility.

(12) The hospital shall report to the department information regarding treatment of traumatic brain injuries. The report must be submitted on a form provided by the department and must include the following information:

(a) Name, age, and residence of the injured person; and

(b) Other information as requested by the department which is currently available and collected by computer in the medical records department of the treating hospital.

(13) The hospital shall retain legible copies of the following records and reports in the facility in a single file for thirty-six (36) months following their issuance and shall be made available for inspection during normal business hours to any patient who requests to view them:

(a) Local fire safety inspections;

(b) Local building code inspections, if any;

(c) Fire marshal reports;

(d) Department licensure and fire safety inspections and surveys;

(Rule 1200-08-01-.11, continued)

(e) Department quality assurance surveys, including follow-up visits, and certification inspections, if any;

(f) Federal Health Care Financing Administration surveys and inspections, if any;

(g) Orders of the Commissioner or Board, if any;

(h) Comptroller of the Treasury's audit reports and finding, if any; and

(i) Maintenance records of all safety equipment.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-3-102, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, and 68-11-310.* ***Administrative History:*** *Original rule filed March 18, 2000; effective May 30, 2000. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed May 24, 2004; effective August 7, 2004. Amendment filed September 6, 2005; effective November 20, 2005. Amendment filed February 23, 2007; effective May 9, 2007. Amendments filed January 3, 2012; effective April 2, 2012.*

1200-08-01-.12 PATIENT RIGHTS.

(1) Each patient has at least the following rights:

(a) To privacy in treatment and personal care;

(b) To be free from mental and physical abuse. Should this right be violated, the facility must notify the Department within five (5) working days. The Tennessee Department of Human Services, Adult Protection Services shall be notified immediately as required in T.C.A. § 71-6-103;

(c) To refuse treatment. The patient must be informed of the consequences of that decision, the refusal and its reason must be reported to the physician and documented in the medical record;

(d) To refuse experimental treatment and drugs. The patient's or health care decision maker's written consent for participation in research must be obtained and retained in his or her medical record;

(e) To have their records kept confidential and private. Written consent by the patient must be obtained prior to release of information except to persons authorized by law. If the patient lacks capacity, written consent is required from the patient's health care decision maker. The hospital must have policies to govern access and duplication of the patient's record;

(f) To have access to a phone number to call if there are questions or complaints about care;

(g) To have appropriate assessment and management of pain; and

(h) To be involved in the decision making of all aspects of their care.

(2) Each patient has a right to self-determination, which encompasses the right to make choices regarding life-sustaining treatment (including resuscitative services). This right of self-determination may be effectuated by an advance directive.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed March 18, 2000; effective May 30, 2000. Amendment filed*

(Rule 1200-08-01-.12, continued)
June 18, 2002; effective September 1, 2002. Amendments filed September 6, 2005; effective November 20, 2005.

1200-08-01-.13 POLICIES AND PROCEDURES FOR HEALTH CARE DECISION-MAKING.

(1) Pursuant to this Rule, each hospital shall maintain and establish policies and procedures governing the designation of a health care decision-maker for making health care decisions for a patient who is incompetent or who lacks capacity, including but not limited to allowing the withholding of CPR measures from individual patients. 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 patient could have made while having capacity, or may limit the power of the agent, and may include individual instructions. The effect of an advance directive that makes no limitation on the agent's authority shall be to authorize the agent to make any health care decision the patient could have made while having capacity.

(3) The advance directive shall be in writing, signed by the patient, 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 patient by blood, marriage, or adoption and would not be entitled to any portion of the estate of the patient upon the death of the patient. 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 authority of an agent becomes effective only upon a determination that the patient lacks capacity, and ceases to be effective upon a determination that the patient has recovered capacity.

(5) A facility may use any advanced directive form that meets the requirements of the Tennessee Health Care Decisions Act or has been developed and issued by the Board for Licensing Health Care Facilities.

(6) A determination that a patient lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent shall be made by the designated physician, who is authorized to consult with such other persons as he or she may deem appropriate.

(7) An agent shall make a health care decision in accordance with the patient'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 patient's best interest. In determining the patient's best interest, the agent shall consider the patient's personal values to the extent known.

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

(9) A health care facility 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 patient'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

(Rule 1200-08-01-.13, continued)

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 patient 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 patient 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 an 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 an earlier 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 the supervising health care provider. The designation may be oral or written.

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

1. The patient has been determined by the designated physician to lack capacity, and

2. No agent or guardian has been appointed, or

3. The agent or guardian is not reasonably available.

(c) In the case of a patient who lacks capacity, the patient's surrogate shall be identified by the supervising health care provider and documented in the current clinical record of the facility at which the patient is receiving health care.

(d) The patient's surrogate shall be an adult who has exhibited special care and concern for the patient, who is familiar with the patient'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 patient's spouse, unless legally separated;

2. The patient's adult child;

3. The patient's parent;

4. The patient's adult sibling;

5. Any other adult relative of the patient; or

(Rule 1200-08-01-.13, continued)

6. Any other adult who satisfies the requirements of 1200-08-01-.13(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 patient shall be eligible to serve as the patient'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 known wishes of the patient or in accordance with the patient's best interests;

2. The proposed surrogate's regular contact with the patient 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 patient 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 patient lacks capacity and none of the individuals eligible to act as a surrogate under 1200-08-01-.13(16)(c) through 1200-08-01-.13(16)(g) is reasonably available, the designated physician may make health care decisions for the patient 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 patient'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 patient'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 patient's best interest. In determining the patient's best interest, the surrogate shall consider the patient's personal values to the extent known to the surrogate.

(k) A surrogate who has not been designated by the patient may make all health care decisions for the patient that the patient could make on the patient's own behalf, except that artificial nutrition and hydration may be withheld or withdrawn for a patient upon a decision of the surrogate only when the designated physician and a second independent physician certify in the patient's current clinical records that the provision

(Rule 1200-08-01-.13, continued)

or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the patient is highly unlikely to regain capacity to make medical decisions.

(l) Except as provided in 1200-08-01-.13(16)(m):

1. Neither the treating health care provider nor an employee of the treating health care provider, nor an operator of a health care institution nor an employee of an operator of a health care institution may be designated as a surrogate; 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 patient's treating health care provider.

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

1. The employee so designated is a relative of the patient 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 patient to provide written documentation stating facts and circumstances reasonably sufficient to establish the claimed authority.

(17) Guardian.

(a) A guardian shall comply with the patient's individual instructions and may not revoke the patient'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 patient 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 patient 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 the determination in the patient's current clinical record and communicate the determination to the patient, if possible, and to any person then authorized to make health care decisions for the patient.

(19) Except as provided in 1200-08-01-.13(20) through 1200-08-01-.13(22), a health care provider or institution providing care to a patient shall:

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

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

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

(Rule 1200-08-01-.13, continued)

(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 a policy of the institution which is based on reasons of conscience, and

(b) The policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient.

(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 1200-08-01-.13(20) through 1200-08-01-.13(22) shall:

(a) Promptly so inform the patient, if possible, and any person then authorized to make health care decisions for the patient;

(b) Provide continuing care to the patient until a transfer can be effected or until the determination has been made that transfer cannot be effected;

(c) Unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision; 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 patient has the same rights as the patient 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 patient, 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 for such identification made in good faith.

(Rule 1200-08-01-.13, continued)

(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 patient 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) Physician Orders for Scope of Treatment (POST)

(a) Physician Orders for Scope of Treatment (POST) may be issued by a physician for a patient with whom the physician has a bona fide physician-patient relationship, but only:

1. With the informed consent of the patient;

2. If the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon 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, if the physician determines that the provision of cardio pulmonary resuscitation would be contrary to accepted medical standards.

(b) A POST may be issued by a physician assistant, nurse practitioner or clinical nurse specialist for a patient with whom such physician assistant, nurse practitioner or clinical nurse specialist has a bona fide physician assistant-patient or nurse-patient relationship, but only if:

1. No physician, who has a bona fide physician-patient relationship with the patient, is present and available for discussion with the patient (or if the patient is a minor or is otherwise incapable of making an informed decision, with the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act);

2. Such authority to issue is contained in the physician assistant's, nurse practitioner's or clinical nurse specialist's protocols;

3. Either:

(i) The patient is a resident of a nursing home licensed under title 68 or an ICF/MR facility licensed under title 33 and is in the process of being discharged from the nursing home or transferred to another facility at the time the POST is being issued; or

(ii) The patient is a hospital patient and is in the process of being discharged from the hospital or transferred to another facility at the time the POST is being issued; and

4. Either:

(i) With the informed consent of the patient;

(Rule 1200-08-01-.13, continued)

(ii) If the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon 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

(iii) 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 and such authority to issue is contained in the physician assistant, nurse practitioner or clinical nurse specialist's protocols and the physician assistant or nurse determines that the provision of cardiopulmonary resuscitation would be contrary to accepted medical standards.

(c) If the patient is an adult who is capable of making an informed decision, the patient's expression of the desire to be resuscitated in the event of cardiac or respiratory arrest shall revoke any contrary order in the POST. If the patient is a minor or is otherwise incapable of making an informed decision, the expression of the desire that the patient be resuscitated by the person authorized to consent on the patient's behalf shall revoke any contrary order in the POST. Nothing in this section shall be construed to require cardiopulmonary resuscitation of a patient for whom the physician or physician assistant or nurse practitioner or clinical nurse specialist determines cardiopulmonary resuscitation is not medically appropriate.

(d) A POST issued in accordance with this section shall remain valid and in effect until revoked. In accordance with this rule and applicable regulations, 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, the Department of Mental Health and Substance Abuse Services, or the Department of Intellectual and Developmental Disabilities, or operated, licensed, or owned by another state agency, shall follow a POST that is available to such persons in a form approved by the Board for Licensing Health Care Facilities.

(e) Nothing in these rules shall authorize the withholding of other medical interventions, such as medications, positioning, wound care, oxygen, suction, treatment of airway obstruction or other therapies deemed necessary to provide comfort care or alleviate pain.

(f) If a person has a do-not-resuscitate order in effect at the time of such person's discharge from a health care facility, the facility shall complete a POST prior to discharge. If a person with a POST 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 POST to qualified emergency medical service personnel and to the receiving facility prior to the transfer. The transferring facility shall provide a copy of the POST that accompanies the patient in transport to the receiving health care facility. Upon admission, the receiving facility shall make the POST a part of the patient's record.

(g) These rules shall not prevent, prohibit, or limit a physician from using a written order, other than a POST, not to resuscitate a patient in the event of cardiac or respiratory arrest in accordance with accepted medical practices. This action shall have no application to any do not resuscitate order that is not a POST, as defined in these rules.

(Rule 1200-08-01-.13, continued)

(h) Valid do not resuscitate orders or emergency medical services do not resuscitate orders issued before July 1, 2004, pursuant to then-current law, shall remain valid and shall be given effect as provided in these rules.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-211, 68-11-224, and 68-11-1801 through 68-11-1815.* ***Administrative History:*** *Original rule filed March 18, 2000; effective May 30, 2000. Amendment filed April 28, 2003; effective July 12, 2003. Repeal and new rule filed September 6, 2005; effective November 20, 2005. Amendment filed February 7, 2007; effective April 23, 2007. Amendments filed January 3, 2012; effective April 2, 2012. Amendment filed March 27, 2015; effective June 25, 2015.*

1200-08-01-.14 DISASTER PREPAREDNESS.

(1) Emergency Electrical Power.

(a) All hospitals must have one or more on-site electrical generators which are capable of providing emergency electrical power to at least all life sustaining equipment and life sustaining resources such as: ventilators; blood banks, biological refrigerators, safety switches for boilers, safety lighting for corridors and stairwells and other essential equipment.

(b) Connections shall be through a switch which shall automatically transfer the circuits to the emergency power source in case of power failure. (It is recognized that some equipment may not sustain automatic transfer and provisions will have to be made to manually change these items from a non-emergency powered outlet to an emergency powered outlet or other power source).

(c) The emergency power system shall have a minimum of twenty four (24) hours of either propane, natural gas, gasoline or diesel fuel. The quantity shall be based on its expected or known connected load consumption during power interruptions. In addition, the hospital shall have a written contract with an area fuel distributor which guarantees first priority service for re-fills during power interruptions.

(d) The emergency power system shall be inspected weekly and exercised and under actual load and operating temperature conditions for at least thirty (30) minutes, once each month. Records shall be maintained for all inspections and tests and kept on file for a minimum of three (3) years.

(2) Physical Facility and Community Emergency Plans.

(a) Physical Facility (Internal Situations).

1. Every hospital shall have a current internal emergency plan, or plans, that provides for fires, bomb threats, severe weather, utility service failures, plus any local high risk situations such as floods, earthquakes, toxic fumes and chemical spills.

2. The plan(s) must include provisions for the relocation of persons within the building and/or either partial or full building evacuation. Plans that provide for the relocation of patients to other health care facilities must have written agreements for emergency transfers. Their agreements may be mutual, i.e. providing for transfers either way.

3. Copies of the plan(s), either complete or outlines, including specific emergency telephone numbers related to that type of disaster, shall be available to all staff. Provisions that have security implications may be omitted from the outline

(Rule 1200-08-01-.14, continued)

versions. Familiarization information shall be included in employee orientation sessions and more detailed instructions must be included in continuing education programs. Records of orientation and education programs must be maintained for at least three (3) years.

4. Drills of the disaster preparedness plan shall be conducted at least once a year. The risk focus may vary by type of drill. Drills are for the purpose of educating staff, resource determination, testing personal safety provisions and communications with other facilities and community agencies. Records which document and evaluate these drills must be maintained for at least three (3) years.

5. As soon as possible, real situations that result in a response by local authorities must be documented. This includes a critique of the activation of the plan. Actual documented situations that had education and training value may be substituted for a drill.

(b) Community Emergency (Mass Casualty).

1. Every hospital, unless exempted due to its limited scope of clinical services, shall have a plan that provides for the reception and treatment, within its capabilities, of medical emergencies resulting from a disaster within its usual service area. The plan should consider the probability of the types of disasters which might occur, both natural and “man-made”.

2. The plan must provide for additional staffing, medical supplies, blood and other resources which would probably be needed. The plan must also include for the deferral of elective admission patients and also for the early transfer or discharge of some current patients if it appears that the number of casualties will exceed available staffed beds.

3. Copies of the plan(s), either complete or outlines, including specific emergency telephone numbers related to that type of disaster, shall be available to staff who would be assigned non-routine duties during these types of emergencies. Familiarization information shall be included in employee orientation sessions and more detailed instruction must be included in continuing education programs. Records of orientation and education must be maintained for at least three (3) years.

4. At least one drill shall be conducted each year for the purpose of educating staff, resource determination, and communications with other facilities and community agencies. Records which document and evaluate these drills must be maintained for at least three (3) years.

5. As soon as possible, actual community emergency situations that result in the treatment of more than twenty (20) patients, or fifteen percent (15%) of the licensed bed capacity, whichever is less, must be documented. Actual situations that had education and training value may be substituted for a drill. This includes documented actual plan activation during community emergencies, even if no patients are received.

(c) Emergency Planning with Local Government Authorities.

1. All hospitals shall establish and maintain communications with the county Emergency Management Agency. This includes the provision of the information and procedures that are needed for the local comprehensive emergency plan.

(Rule 1200-08-01-.14, continued)

The facility shall cooperate, to the extent possible, in area disaster drills and local emergency situations.

2. Each hospital must rehearse both the Physical Facility and Community Emergency plan as required in these regulations, even if the local Emergency Management Agency is unable to participate.

3. A file of documents demonstrating communications and cooperation with the local agency must be maintained.

Authority: *T.C.A. §§ 4-5-202, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed March 18, 2000; effective May 30, 2000.*

1200-08-01-.15 APPENDIX I

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

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	Tennessee Physician Orders for Scope of Treatment (POST, sometimes called "POLST") 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 is not breathing.** ☐ **Resuscitate(CPR)** ☐ **Do Not Attempt Resuscitation (DNR / no CPR) (Allow Natural Death)** When not in cardiopulmonary arrest, follow orders in **B, C,** and **D.**	

(Rule 1200-08-01-.15, continued)

Section B *Check One Box Only*	**MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing.** ☐ **Comfort Measures Only.** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. 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. Treatment Plan: Maximize comfort through symptom management.** ☐ **Limited Additional Interventions.** In addition to care described in Comfort Measures Only above, use medical treatment, antibiotics, IV fluids and cardiac monitoring as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). **Transfer** to hospital if indicated. Generally avoid the intensive care unit. **Treatment Plan: basic medical treatments.** ☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. **Transfer** to hospital and/or intensive care unit if indicated. **Treatment Plan: Full treatment including in the intensive care unit.** *Other Instructions:*_____
Section C *Check One*	**ARTIFICIALLY ADMINISTERED NUTRITION. Oral fluids & nutrition must be offered if feasible.** ☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube. ☐ Long-term artificial nutrition by tube. *Other Instructions:*_____

Section D *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/NP/CNS/PA Name (Print)	**Physician/NP/CNS/PA Signature Date** NP/CNS/PA (Signature at Discharge)	**MD/NP/CNS/PA Phone Number:**

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

Preferences have been expressed to a physician and/or health care professional. It can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)
Agent/Surrogate	Relationship	Phone Number
Health Care Professional Preparing Form	Preparer Title	Phone Number / Date Prepared

[redacted]

(Rule 1200-08-01-.15, continued)

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.

To be valid, POST must be signed by a physician or, at discharge or transfer from a hospital or long term care facility, by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Persons with DNR in effect at time of discharge must have POST completed by health care facility prior to discharge and copy of POST provided to qualified medical emergency personnel.

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 Health Care Agent or 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 D and write "VOID" in large letters if POST is replaced or becomes invalid.

(2) Advance Directive for Health Care Form

ADVANCE DIRECTIVE FOR HEALTH CARE* (Tennessee)

Instructions: Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

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

(Rule 1200-08-01-.15, continued)
decisions myself.

Part I Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____ Home Phone: _____ Work Phone: _____
Address: _____ Mobile Phone: _____ Other Phone: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____ Home Phone: _____ Work Phone: _____
Address: _____ Mobile Phone: _____ Other Phone: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Part 2 Indicate Your Wishes for Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**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.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Indicate Your Wishes for Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ 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.

(Rule 1200-08-01-.15, continued)

☐ Yes	☐ No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Part 3 **Other instructions, such as hospice care, burial arrangements, etc.:** _____

(Attach additional pages if necessary)

Part 4 **Organ donation:** Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

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

☐ No organ/tissue donation

SIGNATURE

Part 5 Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: _____ Date: _____
(Patient)

Block A Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent or alternate. 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 or alternate. 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

Block B You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

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.

(Rule 1200-08-01-.15, continued)

My commission expires: _____ _____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE: (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.* ***Administrative History:*** *Original rule filed February 16, 2007; effective May 2, 2007. Repeal and new rule filed August 28, 2012; effective November 26, 2012. Amendment filed March 27, 2015; effective June 25, 2015. Amendments filed February 8, 2017; effective May 9, 2017.*

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

CHAPTER 1200-08-06
STANDARDS FOR NURSING HOMES

TABLE OF CONTENTS

1200-08-06-.01 DEFINITIONS.

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

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

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

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

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

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

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

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

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

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

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

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

(12) Competent. A resident who has capacity.

(13) Department. The Tennessee Department of Health.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(43) NFPA. The National Fire Protection Association.

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

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

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

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

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

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

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

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

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

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

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

(c)

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

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

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

3. Specify both 1 and 2.

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

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

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

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

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

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

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

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

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

(62) Shall or Must. Compliance is mandatory.

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

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

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

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

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

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

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

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

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

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

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

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

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

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 39-11-106, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-224, 68-11-234, 68-11-1802, and 71-6-121.* ***Administrative History:*** *Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed April 10, 2000; effective June 24, 2000. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed April 28, 2003; effective July 12, 2003. Amendments filed September 21, 2005; effective December 5, 2005. Amendment filed February 7, 2007; effective April 23, 2007. Amendment filed July 18, 2007; effective October 1, 2007. Amendment filed January 3, 2012; effective April 2, 2012. Amendment filed March 27, 2015; effective June 25, 2015. Amendment filed September 15, 2015; effective December 14, 2015. Amendments filed July 10, 2018; effective October 8, 2018.*

1200-08-06-.02 LICENSING PROCEDURES.

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

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

(a) The applicant shall submit an application on a form provided by the department along with a copy of the Certificate of Need (CON) issued by the Tennessee Health Services and Development Agency (HSDA). Any condition placed on the CON will also be placed on the license.

(Rule 1200-08-06-.02, continued)

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

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

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

(e) The applicant shall allow the nursing home to be inspected by a Department surveyor. In the event that deficiencies are noted, the applicant shall submit a plan of corrective action to the Board that must be accepted by the Board. Once the deficiencies have been corrected, then the Board shall consider the application for licensure.

(3) A proposed change of ownership, including a change in a controlling interest, must be reported to the department a minimum of thirty (30) days prior to the change. A new application and fee must be received by the department before the license may be issued.

(a) For the purpose of licensing, the licensee of a nursing home has the ultimate responsibility for the operation of the facility, including the final authority to make or control operational decisions and legal responsibility for the business management. A change of ownership occurs whenever this ultimate legal authority for the responsibility of the nursing home's operation is transferred.

(b) A change of ownership occurs whenever there is a change in the legal structure by which the nursing home is owned and operated.

(c) Transactions constituting a change of ownership include, but are not limited to, the following:

1. Transfer of the facility's legal title;

2. Lease of the facility's operations;

3. Dissolution of any partnership that owns, or owns a controlling interest in, the facility.

4. One partnership is replaced by another through the removal, addition or substitution of a partner;

5. Removal of the general partner or general partners, if the facility is owned by a limited partnership;

6. Merger of a facility 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 facility owner with one or more corporations; or,

(Rule 1200-08-06-.02, continued)

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. Two (2) or more corporations merge and the originally-licensed corporation survives;

3. Changes in the membership of a non-profit corporation;

4. Transfers between departments of the same level of government; or,

5. Corporate stock transfers or sales, even when a controlling interest.

(e) Management agreements are generally not changes of ownership if the owner continues to retain ultimate authority for the operation of the facility. However, if the ultimate authority is surrendered and transferred from the owner to a new manager, then a change of ownership has occurred.

(f) Sale/lease-back agreements shall not be treated as changes in ownership if the lease involves the facility's entire real and personal property and if the identity of the leasee, who shall continue the operation, retains the same legal form as the former owner.

(4) Each nursing home, except those operated by the U.S. Government or the State of Tennessee, making application for license under this chapter shall pay annually to the department a fee based on the number of nursing home beds, as follows:

(a)	Less than 25 beds	$ 1,040.00
(b)	25 to 49 beds, inclusive	$ 1,300.00
(c)	50 to 74 beds, inclusive	$ 1,560.00
(d)	75 to 99 beds, inclusive	$ 1,820.00
(e)	100 to 124 beds, inclusive	$ 2,080.00
(f)	125 to 149 beds, inclusive	$ 2,340.00
(g)	150 to 174 beds, inclusive	$ 2,600.00
(h)	175 to 199 beds, inclusive	$ 2,860.00

For nursing homes of two hundred (200) beds or more the fee shall be two thousand eight hundred and sixty dollars ($2,860.00) 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. When additional beds are licensed, the licensing procedures for new facilities must be followed and the difference between the fee previously paid and the fee for the new bed capacity, if any, must be paid.

(5) Renewal.

(Rule 1200-08-06-.02, continued)

(a) In order to renew a license, each nursing home shall submit to periodic inspections by Department surveyors for compliance with these rules. If deficiencies are noted, the licensee shall submit an acceptable plan of corrective action and shall remedy the deficiencies. In addition, each licensee shall submit a renewal form approved by the board and applicable renewal fee prior to the expiration date of the license.

(b) If a licensee fails to renew its license prior to the date of its expiration but submits the renewal form and fee within sixty (60) days thereafter, the licensee may renew late by paying, in addition to the renewal fee, a late penalty of one hundred dollars ($100) per month for each month or fraction of a month that renewal is late; provided that the late penalty shall not exceed twice the renewal fee.

(c) In the event that a licensee fails to renew its license within the sixty (60) day grace period following the license expiration date, then the licensee shall reapply for a license by submitting the following to the Board office:

1. A completed application for licensure;

2. The license fee provided in rule 1200-08-06-.02(4); and

3. Any other information required by the Health Services and Development Agency.

(d) Upon reapplication, the licensee shall submit to an inspection of the facility by Department of Health surveyors.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-209(a)(1), 68-11-210, 68-11-216, Chapter 846 of the Public Acts of 2008, § 1, and T.C.A. § 68-11-206(a)(5) [effective January 1, 2009].* ***Administrative History:*** *Original rules filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Amendment filed March 13, 1986; effective April 12, 1986. Amendment filed December 30, 1986; effective February 13, 1987. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed November 19, 2003; effective February 2, 2004. Amendment filed September 21, 2005; effective December 5, 2005. Amendment filed January 19, 2007; effective April 4, 2007. Public necessity rules filed April 29, 2009; effective through October 11, 2009. Emergency rules filed October 9, 2009; effective through April 7, 2010. Amendments filed September 24, 2009; effective December 23, 2009. Amendment filed December 16, 2013; effective March 16, 2014. Amendments filed March 21, 2018; to have been effective June 19, 2018. However, on May 24, 2018, the Government Operations Committee filed a 5-day stay; new effective date June 24, 2018.*

1200-08-06-.03 DISCIPLINARY PROCEDURES.

(1) The board may suspend or revoke a license for:

(a) Violation of federal statutes or rules;

(b) Violation of state statutes or the rules as set forth in this chapter;

(c) Permitting, aiding or abetting the commission of any illegal act in the nursing home;

(d) Conduct or practice found by the board to be detrimental to the health, safety, or welfare of the residents of the nursing home; and,

(e) Failure to renew the license.

(2) The board may consider all factors which it deems relevant, including but not limited to the following, when determining sanctions:

(Rule 1200-08-06-.03, continued)

(a) The degree of sanctions necessary to ensure immediate and continued compliance;

(b) The character and degree of impact of the violation on the health, safety and welfare of the residents in the facility;

(c) The conduct of the facility in taking all feasible steps or procedures necessary or appropriate to comply or correct the violation; and,

(d) Any prior violations by the facility of statutes, rules or orders of the commissioner or the board.

(3) The Board shall have the authority to place a facility on probation. To be considered for probation, a facility must have had at least two (2) separate substantiated complaint investigation surveys within six (6) months, where each survey had at least one deficiency cited at the level of substandard quality of care or immediate jeopardy, as those terms are defined at 42 CFR 488.301. None of the surveys can have been initiated by an unusual event or incident self reported by the facility.

(a) If a facility meets the criteria for probation, the board may hold a hearing at its next regularly scheduled meeting to determine if the facility should be placed on probation. Prior to initiating such a hearing, the board shall provide notice to the facility detailing what specific non-compliance the board had identified that the facility must respond to at the probation hearing.

(b) Prior to imposing probation, the board may consider and address in its findings all factors which it deems relevant, including, but not limited to, the following:

1. What degree of sanctions is necessary to ensure immediate and continued compliance; and

2. Whether the non-compliance was an unintentional error or omission, or was not fully within the control of the facility; and

3. Whether the nursing home recognized the non-compliance and took steps to correct the identified issues, including whether the facility notified the department of the non-compliance either voluntarily or as required by state law or regulations; and

4. The character and degree of impact of the non-compliance on the health, safety and welfare of the patient or patients in the facility; and

5. The conduct of the facility in taking all feasible steps or procedures necessary or appropriate to comply or correct the non-compliance; and

6. The facility’s prior history of compliance or non-compliance.

(4) If the Board places a facility on probation, the facility shall detail in a plan of correction those specific actions, which when followed, will correct the non-compliance identified by the board.

(5) During the period of probation, the facility must make reports on a schedule determined by the board. These reports must demonstrate and explain to the board how the facility is implementing the actions identified in its plan of correction. In making such reports, the board shall not require the facility to disclose any information protected as privileged and confidential under any state or federal law or regulation.

(Rule 1200-08-06-.03, continued)

(6) The Board is authorized at any time during the probation to remove the probation~~al~~ status of the facility's license, based upon information presented to it showing that the conditions identified by the board have been corrected and are reasonably likely to remain corrected.

(7) The Board must rescind the probational status of the facility if it determines that the facility has complied with its plan of correction as submitted and approved by the board, unless the facility has additional non-compliance that warrants an additional term of probation as defined in T.C.A. § 68-11-207(e)(1).

(8) A single period of probation for a facility shall not extend beyond twelve (12) months. If the board determines during or at the end of the probation that the facility is not taking steps to correct non-compliance or otherwise not responding in good faith pursuant to the plan of correction, the board may take any additional action as authorized by law.

(9) The hearing to place a facility on probation and judicial review of the board's decision shall be in accordance with the Uniform Administrative Procedures Act.

(10) When a nursing home is found by the department to have committed a violation of this chapter, the department will issue to the facility a statement of deficiencies. Within ten (10) days of the receipt of the statement of deficiencies, the facility must return a plan of correction indicating 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.

(11) Either failure to submit a plan of correction in a timely manner or a finding by the department that the plan of correction is unacceptable shall subject the nursing home's license to possible disciplinary action.

(12) Whenever the commissioner exercises the authority to suspend the admission of any new resident(s) to the nursing home because of detrimental conditions, as provided by T.C.A. § 68-11-207(b), the nursing home shall post a copy of the commissioner's order upon the public entrance doors of the facility and prominently display it there for so long as it remains effective. During the suspension of admissions, the nursing home shall inform any person who inquires about the admission of a new resident of the provisions of the order and make a copy of the order available.

(13) Any licensee or applicant for a license, aggrieved by a decision or action of the department or board, pursuant to this chapter, may request a hearing before the board. The proceedings and judicial review of the board's decision shall be in accordance with the Uniform Administrative Procedures Act, T.C.A. §§ 4-5-101, et seq.

(14) Reconsideration and Stays. The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-04-01-.18 regarding petitions for reconsiderations and stays in that case.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 4-5-219, 4-5-312, 4-5-316, 4-5-317, 68-11-202, 68-11-204, and 68-11-206 through 68-11-209.* ***Administrative History:*** *Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Amendment filed March 13,*

(Rule 1200-08-06-.03, continued)

1986; effective April 12, 1986. Amendment filed December 30, 1986; effective February 13, 1987. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed May 24, 2004; August 7, 2004. Amendment filed March 1, 2007; effective May 15, 2007.

1200-08-06-.04 ADMINISTRATION.

(1) The nursing home shall have a full-time (working at least 32 hours per week) administrator licensed in Tennessee, who shall not function as the director of nursing. Any change of administrators shall be reported in writing to the department within fifteen (15) days. The administrator shall designate in writing an individual to act in his/her absence in order to provide the nursing home with administrative direction at all times. The administrator shall assure the provision of appropriate fiscal resources and personnel required to meet the needs of the residents.

(2) The hospital administrator may serve as the administrator of a hospital-based nursing home provided that he/she is a Tennessee licensed nursing home administrator, the facilities are located on the same campus, and the surveys do not reflect substandard care.

(3) Any agreement to manage a nursing home must be reported in writing to the department within fifteen (15) days of its implementation.

(4) Upon the unexpected loss of the facility administrator, the facility shall proceed according to the following provisions:

(a) The term “unexpected loss” means the absence of a nursing home administrator due to serious illness or incapacity, unplanned hospitalization, death, resignation with less than thirty (30) days’ notice or unplanned termination.

(b) The facility must notify the department within twenty-four (24) hours after notice of the unexpected loss of the administrator. Notification to the department shall identify an individual to be responsible for administration of the facility for the immediate future not to exceed thirty (30) days. This responsible individual need not be licensed as an administrator and may be the facility’s director of nursing.

(c) Within seven (7) days of notice of the unexpected loss, the facility must request a waiver of the appropriate regulations from the board.

(d) On or before the expiration of thirty (30) days after notice of the unexpected loss, the facility shall appoint a temporary administrator to serve until either a permanent administrator is employed or the request for a waiver is considered by the board, whichever occurs first. The temporary administrator shall be any of the following:

1. A full-time administrator licensed in Tennessee or any other state;

2. One (1) or more part-time administrators licensed in Tennessee. Part-time shall not be less than twenty (20) hours per week; or,

3. A full-time candidate for licensure as a Tennessee administrator who has completed the required training and the application process. Such candidate shall be scheduled for the next licensure exam and is eligible for the continued administrator role only with the successful completion of that exam.

(e) The procedures set forth above shall be followed until the next regularly scheduled meeting of the board in which the board considers the facility’s application for a waiver. After reviewing the circumstances, the board may grant, refuse or condition a waiver as necessary to protect the health, safety and welfare of the residents in the facility.

(f) Any facility which follows these procedures shall not be subject to a civil penalty for absence of an administrator at any time preceding the board's consideration of the facility's request for a waiver.

(5) The facility shall make reasonable efforts to safeguard personal property and promptly investigate complaints of such loss. A record shall be prepared of all clothing, personal possessions and money brought by the resident to the nursing home at the time of admission. The record shall be filled out in duplicate. One copy of the record shall be given to the resident or the resident's representative and the original shall be maintained in the nursing home record. This record shall be updated as additional personal property is brought to the facility.

(6) The facility shall maintain a surety bond on all resident funds held in trust. Such surety bonds shall be sufficient to cover the amount of such funds. The surety bond shall be an agreement between the company issuing the bond and the nursing home and shall remain in the possession of the nursing home.

(7) If the facility holds resident funds, such funds shall be kept in an account separate from the facility's funds. Resident funds shall not be used by the facility. The facility shall maintain and allow each resident access to a written record of all financial arrangements and transactions involving the individual resident's funds. The facility shall provide each resident or his/her representative with a written itemized statement at least quarterly of all financial transactions involving the resident's funds.

(8) Within thirty (30) days of a resident's death, the facility shall provide an accounting of the resident's funds held by the facility and an inventory of the resident's personal property held by the facility to the resident's executor, administrator or other person authorized by law to receive the decedent's property. The facility shall obtain a signed receipt from any person to whom the decedent's property is transferred.

(9) Upon the sale of the facility, the seller shall provide written verification that all the resident's funds and property have been transferred and shall obtain a signed receipt from the new owner. Upon receipt, the buyer shall provide, to the residents, an accounting of funds and property held on their behalf.

(10) When licensure is applicable for a particular job, verification of the current license must be included as a part of the personnel file. Each personnel file shall contain accurate information as to the education, training, experience and personnel background of the employee. Documentation that references were verified shall be on file. Documentation that all appropriate abuse registries have been checked shall be on file. Adequate medical screenings to exclude communicable disease shall be required of each employee.

(11) Prior to employment, all nursing homes shall complete a criminal background check on any person who will be in a position which involves providing direct care to a resident or patient.

(a) Any person who applies for employment in a position which involves providing direct patient care to a resident in such a facility shall consent to:

1. Provide past work and personal references to be checked by the nursing home; and/or

2. Agree to release and use of any and all information and investigative records necessary for the purpose of verifying whether the individual has been convicted of a criminal offense in the state of Tennessee, to either the nursing home or its

(Rule 1200-08-06-.04, continued)

agent, to any agency that contracts with the state of Tennessee, to any law enforcement agency, or to any other legally authorized entity; and/or

3. Supply a fingerprint sample and submit to a state criminal history records check to be conducted by the Tennessee Bureau of Investigations, or a state and federal criminal history records check to be conducted by the Tennessee Bureau of Investigation and the Federal Bureau of Investigation; and/or

4. Release any information required for a criminal background investigation by a professional background screening organization or criminal background check service or registry.

(b) A nursing home shall not disclose criminal background check information obtained to a person who is not involved in evaluating a person's employment, except as required or permitted by state or federal law.

(c) Any costs incurred by the Tennessee Bureau of Investigation, professional background screening organization, law enforcement agency, or other legally authorized entity, in conducting such investigations of such applicants may be paid by the nursing home, or any agency that contracts with the state of Tennessee requesting such investigation and information, or the individual who seeks employment or is employed. Payment of such costs to the Tennessee Bureau of Investigation are to be made in accordance with T.C.A. §§ 38-6-103 and 38-6-109. The costs of conducting criminal background checks shall be an allowable cost under the state Medicaid program, if paid for by the nursing home.

(d) Criminal background checks are also required by any organization, company, or agency that provides or arranges for the supply of direct care staff to any nursing home licensed in the state of Tennessee. Such company, organization, or agency shall be responsible for initiating a criminal background check on any person hired by that entity for the purpose of working in a nursing home, and shall be required to report the results of the criminal background check to any facility in which the organization arranges the employee to work, upon request by a facility.

(e) A nursing home that declines to employ or terminates a person based upon criminal background information provided to the facility shall be immune from suit by or on behalf of that person for the termination of or the refusal to employ that person.

(12) Whenever the rules of this chapter require that a licensee develop a written policy, plan, procedure, technique, or system concerning a subject, the licensee shall develop the required policy, maintain it and adhere to its provisions. A nursing home which violates a required policy also violates the rule establishing the requirement.

(13) Policies and procedures shall be consistent with professionally recognized standards of practice.

(14) No nursing home shall retaliate against or, in any manner, discriminate against any person because of a complaint made in good faith and without malice to the board, the department, the Department of Human Services Adult Protective Services, the long term care ombudsman, the Comptroller of the State Treasury, or any government agency. A nursing home shall neither retaliate, nor discriminate, because of information lawfully provided to these authorities, because of a person's cooperation with them, or because a person is subpoenaed to testify at a hearing involving one of these authorities.

(15) Each nursing home shall adopt safety policies for the protection of residents from accident and injury.

(Rule 1200-08-06-.04, continued)

(16) Each nursing home shall post whether they have 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 displayed at the main public entrance.

(17) Documentation pertaining to the payment agreement between the nursing home and the resident shall be completed prior to admission. A copy of the documentation shall be given to the resident and the original shall be maintained in the nursing home records.

(18) The nursing home shall ensure a framework for addressing issues related to care at the end of life.

(19) The nursing home shall provide a process that assesses pain in all patients. There shall be an appropriate and effective pain management program.

(20) The nursing home shall carry out the following functions, all of which shall be documented in a written medical equipment management plan:

(a) Develop and maintain a current itemized inventory of medical equipment used in the facility, that is owned or leased by the operator of the facility;

(b) Develop and maintain a schedule for the maintenance, inspection and testing of medical equipment according to manufacturers' recommendations or other generally accepted standards. The schedule shall include the date and time such maintenance, inspection and testing was actually performed, and the name of the individual who performed such tasks; and

(c) Ensure maintenance, inspection and testing were conducted by facility personnel adequately trained in such procedures or by a contractor qualified to perform such procedures.

(21) All health care facilities licensed pursuant to T.C.A. §§ 68-11-201, *et seq.* shall post on a sign no smaller than eight and one-half inches (8½") in width and eleven inches (11") in height the following in the main public entrance:

(a) a statement that any person, regardless of age, who may be the victim of domestic violence may call the nationwide domestic violence hotline, with that number printed in boldface type, for immediate assistance.

(22) "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.

(23) Residents of the facility are exempt from the smoking prohibition. The resident smoking practices shall be governed by the policies and procedures established by the facility. Smoke from such areas shall not infiltrate into the areas where smoking is prohibited.

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

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 39-17-1803, 39-17-1804, 39-17-1805, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-225, 68-11-254, 68-11-256, 68-11-257, 68-11-268, 68-11-906, and 71-6-121.* ***Administrative History:*** *Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Amendment filed May 24, 1985; effective June 23, 1985. Amendment filed March 13, 1986; effective April 12, 1986. Amendment filed October 22, 1987; effective*

(Rule 1200-08-06-.04, continued)

December 6, 1987. Amendment filed May 10, 1990; effective June 24, 1990. Amendment filed March 9, 1992; effective April 23, 1992. Amendment filed March 10, 1995; effective May 24, 1995. Amendment filed June 13, 1997; effective August 27, 1997. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed June 18, 2002; effective September 1, 2002. Amendment filed May 24, 2004; effective August 7, 2004. Amendment filed February 23, 2007; effective May 9, 2007. Amendment filed July 18, 2007; effective October 1, 2007. Amendment filed February 22, 2010; effective May 23, 2010. Amendment filed October 20, 2015; effective January 18, 2016.

1200-08-06-.05 ADMISSIONS, DISCHARGES, AND TRANSFERS.

(1) Every person admitted for care or treatment shall be under the supervision of a physician who holds a license in good standing to practice in Tennessee. The name of the resident's attending physician shall be recorded in the resident's medical record. The nursing home shall not admit the following types of residents:

(a) Persons who pose a clearly documented danger to themselves or to other residents in the nursing home.

(b) Children under fourteen (14) years of age, except when the department has approved the admission of a specific child.

(c) Persons for whom the nursing home is not capable of providing the care ordered by the attending physician. Documentation of the reason(s) for refusal of the admission shall be maintained.

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

(3) Prior to the admission of a resident to a nursing home or prior to the execution of a contract for the care of a resident in a nursing home (whichever occurs first), each nursing home shall disclose in writing to the resident or to the resident's guardian, conservator or representative, if any, whether the facility has liability insurance and the identity of the primary insurance carrier. If the facility is self-insured, their statement shall reflect that fact and indicate the corporate entity responsible for payment of any claims.

(4) Any residential facility licensed by the board of licensing health care facilities shall upon admission provide to each resident the division of adult protective services' statewide toll-free number: 888-277-8366.

(5) Facilities utilizing secured units must be able to provide survey staff with twelve (12) months of the following performance information specific to the secured unit and its residents:

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

(b) Ongoing and up-to-date documentation of quarterly review by each resident's interdisciplinary team 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 is recorded on a daily basis. The staffing pattern must ensure that there is a minimum of one (1) attendant, awake,

(Rule 1200-08-06-.05, continued)

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 and has received 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~~ 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.

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

(7) Any admission in excess of the licensed bed capacity is prohibited except when an emergency admission is directed by the department.

(8) No resident shall be discharged without a written order from the attending physician or through other legal processes and timely notification of next of kin and/or sponsor or authorized representative, if any. Each nursing home shall establish a policy for handling patients who wish to leave against medical advice.

(9) When a resident is discharged, a brief description of the significant findings and events of the resident's stay in the nursing home, the condition on discharge and the recommendation and arrangement for future care, if any, shall be provided.

(10) No resident shall be transferred without a written order from the attending physician or through other legal processes and timely notification of next of kin and/or sponsor or authorized representative, if any.

(11) When a resident is transferred, a summary of treatment given at the nursing home, condition of the resident at time of transfer and date and place to which he is transferred shall be entered in the record. If the transfer is due to an emergency, this information will be recorded within forty-eight (48) hours, otherwise, it will precede the transfer of the resident.

(12) When a resident is transferred, a copy of the clinical summary shall, with consent of the resident, be sent to the nursing home that will continue the care of the resident.

(13) Where an involuntary transfer is proposed, in addition to any other relevant factors, the following factors shall be taken into account:

(Rule 1200-08-06-.05, continued)

(a) The traumatic effect on the resident.

(b) The proximity of the proposed nursing home to the present nursing home and to the family and friends of the resident.

(c) The availability of necessary medical and social services at the proposed nursing home.

(d) Compliance by the proposed nursing home with all applicable Federal and State regulations.

(14) When the attending physician has ordered a resident transferred or discharged, but the resident or a representative of the resident opposes the action, the nursing home shall counsel with the resident, the next of kin, sponsor and representative, if any, in an attempt to resolve the dispute and shall not transfer the resident until such counseling has been provided. No involuntary transfer or discharge shall be made until the nursing home has first informed the department and the area long-term care ombudsman. Unless a disaster occurs on the premises or the attending physician orders the transfer as a medical emergency (due to the resident's immediate need for a higher level of care) no involuntary transfer or discharge shall be made until five (5) business days after these agencies have been notified, unless they each earlier declare that they have no intention of intervening.

(15) Except when the Board has revoked or suspended the license, a nursing home which intends to close, cease doing business, or reduce its licensed bed capacity by ten percent (10%) or more shall notify both the department and the area long-term care ombudsman at the earliest moment of the decision, but not later than thirty (30) days before the action is to be implemented. The facility shall establish a protocol, subject to the department's approval, for the transfer or discharge of the residents. Should the nursing home violate the provisions of this paragraph, the department shall request the Attorney General of the State of Tennessee to intervene to protect the residents, as is provided by T.C.A. § 68-11-213(a).

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-257, and 71-6-121.* ***Administrative History:*** *Original rule filed March 27; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed April 10, 2000; effective June 24, 2000. Amendment filed February 23, 2007; effective May 9, 2007. Amendment filed April 17, 2007; effective July 1, 2007.*

1200-08-06-.06 BASIC SERVICES.

(1) Performance Improvement.

(a) The nursing home must ensure that there is an effective, facility-wide performance improvement program to evaluate resident care and performance of the organization.

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

1. All organized services related to resident care, including services furnished by a contractor, are evaluated;

2. Nosocomial infections and medication therapy are evaluated;

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

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

4. The facility shall develop and implement a system for measuring improvements in adherence to the hand hygiene program and influenza vaccination program.

(c) The nursing home must have an ongoing plan, consistent with available community and facility resources, to provide or make available services that meet the medically-related needs of its residents.

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

(e) Performance improvement program records are not disclosable, except when such disclosure is required to demonstrate compliance with this section.

(f) Good faith attempts by the performance improvement program committee to identify and correct deficiencies will not be used as a basis for sanctions.

(2) Physician Services.

(a) Policies and procedures concerning services provided by the nursing home shall be available for the admitting physicians.

(b) Residents shall be aided in receiving dental care as deemed necessary.

(c) Each nursing home shall retain by written agreement a physician to serve as a Medical Director.

(d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall:

1. Delineate the responsibilities of and communicate with attending physicians to ensure that each resident receives medical care;

2. Ensure the delivery of emergency and medical care when the resident's attending physician or his/her designated alternate is unavailable;

3. Review reports of all accidents or unusual incidents occurring on the premises, identifying hazards to health and safety and recommending corrective action to the administrator;

4. Make periodic visits to the nursing home to evaluate the existing conditions and make recommendations for improvements;

5. Review and take appropriate action on reports from the Director of Nursing regarding significant clinical developments;

6. Monitor the health status of nursing home personnel to ensure that no health conditions exist which would adversely affect residents; and,

7. Advise and provide consultation on matters regarding medical care, standards of care, surveillance and infection control.

(3) Infection Control.

(a) The nursing home must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active

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

program for the prevention, control, and investigation of infections and communicable diseases.

(b) The physical environment shall be maintained in such a manner to assure the safety and well-being of the residents.

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

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

3. Telephones shall be readily accessible and at least one (1) shall be equipped with sound amplification and shall be accessible to wheelchair residents.

4. Equipment and supplies for physical examination and emergency treatment of residents shall be available.

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

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

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

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

9. The facility shall have written policies and procedures governing care of residents during the failure of the air conditioning, heating or ventilation system, including plans for hypothermia and hyperthermia. When the temperature of any resident area falls below 65°F or exceeds 85°F, or is reasonably expected to do so, the facility shall be alerted to the potential danger, and the department shall be notified.

(c) The administrator shall assure that an infection control program including members of the medical staff, nursing staff and administrative staff develop guidelines and techniques for the prevention, surveillance, control and reporting of facility infections. Duties of the program shall include the establishment of:

1. Written infection control policies;

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

3. Written procedures governing the use of aseptic techniques and procedures in the facility;

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

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

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

7. Continuing education for all facility personnel on the cause, effect, transmission, prevention, and elimination of infections.

(d) The administrator, the medical staff and director of nursing services must ensure that the facility-wide performance improvement program and training programs address problems identified by the infection control program and must be responsible for the implementation of successful corrective action plans in affected problem areas.

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

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

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

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

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

4. Health care worker education programs which may include:

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

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

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

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

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

(g) All nursing homes shall adopt appropriate policies regarding the testing of residents and staff for HIV and any other identified causative agent of acquired immune deficiency syndrome.

(h) The facility shall document evidence of annual vaccination against influenza for each resident, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control most recent to the time of the vaccine. Influenza 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.

The facility shall document evidence of vaccination against pneumococcal disease for all residents who are 65 years of age or older, in accordance with the recommendation 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.

(i) A Nursing Home shall have an annual influenza vaccination program which shall include at least:

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

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

3. Education of all employees about the following:

(i) Flu vaccination,

(ii) Non-vaccine control measures, and

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

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

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

(j) Precautions shall be taken to prevent the contamination of sterile supplies by soiled supplies. Sterile supplies shall be packaged and stored in a manner that protects the sterility of the contents. Decontamination and preparation areas shall be separated.

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

(k) Space and facilities for housekeeping equipment and supply storage shall be provided in each service area. Storage for bulk supplies and equipment shall be located away from patient care areas. The building shall be kept in good repair, clean, sanitary and safe at all times.

(l) The facility shall appoint a housekeeping supervisor who shall be responsible for:

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

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

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

(m) Laundry facilities located in the nursing home shall:

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

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

3. Provide space for storage of clean linen within nursing units and for bulk storage within clean areas of the facility; and,

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

(n) The facility shall name an individual who is responsible for laundry service. This individual shall be responsible for:

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

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

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

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

(4) Nursing Services.

(a) Each nursing home must have an organized nursing service that provides twenty-four (24) hour nursing services furnished or supervised by a registered nurse. Each home shall have a licensed practical nurse or registered nurse on duty at all times and at least two (2) nursing personnel on duty each shift.

(b) The facility must have a well-organized nursing service with a plan of administrative authority and delineation of responsibilities for resident care. The Director of Nursing

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

(DON) must be a licensed registered nurse who has no current disciplinary actions against his/her license. The DON is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the facility.

(c) The Director of Nursing shall have the following responsibilities:

1. Develop, maintain and periodically update:

   (i) Nursing service objectives and standards of practice;

   (ii) Nursing service policy and procedure manuals;

   (iii) Written job descriptions for each level of nursing personnel;

   (iv) Methods for coordination of nursing service with other resident services; and,

   (v) Mechanisms for monitoring quality of nursing care, including the periodic review of medical records.

2. Participate in selecting prospective residents in terms of the nursing services they need and nursing competencies available.

3. Make daily rounds to see residents.

4. Notify the resident's physician when medically indicated.

5. Review each resident's medications periodically and notify the physician where changes are indicated.

6. Supervise the administration of medications.

7. Supervise assignments of the nursing staff for the direct care of all residents.

8. Plan, develop and conduct monthly in-service education programs for nursing personnel and other employees of the nursing home where indicated. An organized orientation program shall be developed and implemented for all nursing personnel.

9. Supervise and coordinate the feeding of all residents who need assistance.

10. Coordinate the dietary requirements of residents with the staff responsible for the dietary service.

11. Coordinate housekeeping personnel.

12. Assure that discharge planning is initiated in a timely manner.

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

(d) The nursing service must have adequate numbers of licensed registered nurses, licensed practical nurses, and certified nurse aides to provide nursing care to all residents as needed. Nursing homes shall provide a minimum of two (2) hours of direct

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

care to each resident every day including 0.4 hours of licensed nursing personnel time. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the availability of a licensed nurse for bedside care of any resident.

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

(f) The facility must ensure that an appropriate individualized plan of care is prepared for each resident with input from appropriate disciplines, the resident and/or the resident's family or the resident's representative.

(g) A registered nurse must assign the nursing care of each resident to other nursing personnel in accordance with the resident's needs and the specialized qualifications and competence of the nursing staff available.

(h) Non-employee licensed nurses who are working in the nursing home must adhere to the policies and procedures of the facility. The director of the nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing service.

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

(j) There must be a facility procedure for reporting adverse drug reactions and errors in administration of drugs.

(k) When non-employees are utilized as sitters or attendants, they shall be under the authority of the nursing service and their duties shall be set forth clearly in written nursing service policies.

(l) Each resident shall be given proper personal attention and care of skin, feet, nails and oral hygiene in addition to the specific professional nursing care as ordered by the resident's physician.

(m) Medications, treatments, and diet shall be carried out as prescribed to safeguard the resident, to minimize discomfort and to attain the physician's objective.

(n) Residents shall have baths or showers at least two (2) times each week, or more often if requested by the resident.

(o) Patients who are bedfast shall have a sponge bath each day.

(p~~o~~) Body position of residents in bed or chair bound shall be changed at least every two (2) hours, day and night, while maintaining good body alignment. Proper skin care shall be provided for bony prominences and weight bearing parts to prevent discomfort and the development of pressure areas, unless contraindicated by physician's orders.

(q~~p~~) Residents who are incontinent shall have partial baths each time the bed or bed clothing has been wet or soiled. The soiled or wet bed linen and the bed clothing shall be replaced with clean, dry linen and clothing immediately after being soiled.

(r~~q~~) Residents shall have shampoos, haircuts and shaves as needed, or desired.

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

(sr) Rehabilitation measures such as assisting patients with range of motion, prescribed exercises and bowel and bladder retraining programs shall be carried out according to the individual needs and abilities of the resident.

(ts) Residents shall be active and out of bed except when contraindicated by written physician's orders.

(ut) Residents shall be encouraged to achieve independence in activities of daily living, self-care, and ambulation as a part of daily care.

(vu) Residents shall have clean clothing as needed and shall be kept free from odor.

(wv) Residents' weights shall be taken and recorded at least monthly unless contraindicated by a physician's order.

(x) Whenever a chemical restraint is administered, the patient shall be observed for adverse reaction and, if found, the drug shall be discontinued immediately and the physician notified.

(yw) Physical restraints shall be checked every thirty (30) minutes and released every two (2) hours so the resident may be exercised and offered toilet access.

(zx) Restraints may be applied or administered to residents only on the signed order of a physician. The signed physician's order must be for a specified and limited period of time and must document the necessity of the restraint. There shall be no standing orders for restraints.

(aay) When a resident's safety or safety of others is in jeopardy, the nurse in charge shall use his/her judgment to use physical restraints if a physician's order cannot be immediately obtained. A written order must be obtained as soon as possible.

(bb) Restraints must be applied in a manner by which they can be speedily removed in case of fire or other emergency.

(ccz) Locked restraints are prohibited.

(ddaa) Assistance with eating shall be given to the resident as needed in order for the resident to receive the diet for good health care.

(eebb) Abnormal food intake will be evaluated and recorded.

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

1. The deceased was a resident of a nursing home;

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

3. The nurse is licensed by the state; and,

4. The nurse is employed by the nursing home in which the deceased resided.

(5) Medical Records.

(a) The nursing home shall comply with the Tennessee Medical Records Act, T.C.A. §§ 68-11-301, et seq.

(b) The nursing home must maintain a medical record for each resident. Medical records must be accurate, promptly completed, properly filed and retained, and accessible. The facility must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.

(c) All medical records, in either written, electronic, graphic or otherwise acceptable form, must be retained in their original or legally reproduced form for a minimum period of at least ten (10) years after which such records may be destroyed. However, in cases of residents under mental disability or minority, their complete facility records shall be retained for the period of minority or known mental disability, plus one (1) year, or ten (10) years following the discharge of the resident, whichever is longer. Records destruction shall be accomplished by burning, shredding or other effective method in keeping with the confidential nature of the contents. The destruction of records must be made in the ordinary course of business, must be documented and in accordance with the facility's policies and procedures, and no record may be destroyed on an individual basis.

(d) When a nursing home closes with no plans of reopening, an authorized representative of the facility may request final storage or disposition of the facility's medical records by the department. Upon transfer to the department, the facility relinquishes all control over final storage of the records and the files shall become property of the State of Tennessee.

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

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

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

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

(i) All records must document the following:

1. Evidence of a physical examination, including a health history, performed no more than ~~thirty~~ sixty (6~~3~~0) days prior to admission~~ or within forty-eight (48) hours following admission~~;

2. Admitting diagnosis;

3. A dietary history as part of each resident's admission record;

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

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

5. Documentation of complications, facility acquired infections, and unfavorable reactions to drugs;

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

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

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

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

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

(6) Pharmaceutical Services.

(a) The nursing home shall have pharmaceutical services that meet the needs of the residents and are in accordance with the Tennessee Board of Pharmacy statutes and rules. The medical staff is responsible for developing policies and procedures that minimize drug errors.

(b) All internal and external medications and preparations intended for human use shall be stored separately. They shall be properly stored in medicine compartments, including cabinets on wheels, or drug rooms. Such cabinets or drug rooms shall be kept securely locked when not in use, and the key must be in the possession of the supervising nurse or other authorized persons. Poisons or external medications shall not be stored in the same compartment and shall be labeled as such.

(c) Schedule II drugs must be stored behind two (2) separately locked doors at all times and accessible only to persons in charge of administering medication.

(d) Every nursing home shall comply with all state and federal regulations governing Schedule II drugs.

(e) A notation shall be made in a Schedule II drug book and in the resident's nursing notes each time a Schedule II drug is given. The notation shall include the name of the resident receiving the drug, name of the drug, the dosage given, the method of administration, the date and time given and the name of the physician prescribing the drug.

(f) All oral orders shall be immediately recorded, designated as such and signed by the person receiving them and countersigned by the physician within ten (10) days.

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

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

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

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

(h) Medications not specifically limited as to time or number of doses when ordered are controlled by automatic stop orders or other methods in accordance with written policies. No Schedule II drug shall be given or continued beyond seventy-two (72) hours without a written order by the physician.

(i) Medication administration records (MAR) shall be checked against the physician's orders. Each dose shall be properly recorded in the clinical record after it has been administered.

(j) Preparation of doses for more than one scheduled administration time shall not be permitted.

(k) Medication shall be administered only by licensed medical or licensed nursing personnel or other licensed health professionals acting within the scope of their licenses.

(l) Unless the unit dose package system is used, individual prescriptions of drugs shall be kept in the original container with the original label intact showing the name of the resident, the drug, the physician, the prescription number and the date dispensed.

(m) Legend drugs shall be dispensed by a licensed pharmacist.

(n) Nursing homes may participate in drug donation repository programs as defined in Title 63, Chapter 10 and may use such programs for drug disposal services. The facility's participation in a drug donation repository program shall be outlined in the facility's policies and procedures.

(o) Alternatively, if a nursing home declines to participate in the drug donation repository program or in the case of drugs not acceptable under the program, any unused portions of prescription drugs shall be turned over to the resident only on a written order by the physician. If not turned over to the resident, such unused drugs left in a nursing home must be destroyed on the premises by a licensed nurse and a witness. The facility's policies and procedures shall outline person(s) who may serve as a witness and methodology. The facility's policies and procedures must be in compliance with applicable DEA regulations.

(7) Radiology Services. The nursing home must maintain or have available diagnostic radiologic services according to the needs of the residents. If therapeutic services are also provided, they, as well as the diagnostic services, must meet professionally approved standards for safety and personnel qualifications.

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

(9) Food and Dietetic Services.

(a) The nursing home must have organized dietary services that are directed and staffed by adequate qualified personnel. A facility may contract with an outside food management company if the company has a dietitian who serves the facility on a full-

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

time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this paragraph and provides for constant liaison with the facility medical staff for recommendations on dietetic policies affecting resident treatment. If an outside contract is utilized for management of its dietary services, the facility shall designate a full-time employee to be responsible for the overall management of the services.

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

1. A qualified dietitian; or,

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

3. An individual who has successfully completed in-person or online coursework that provided ninety (90) or more hours of classroom instruction in food service supervision. If the course has not been completed, this person shall be enrolled in a course and making satisfactory progress for completion within the time limit specified by the course requirement; or,

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

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

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

(d) Menus must meet the needs of the residents.

1. Therapeutic diets must be prescribed by the practitioner or practitioners responsible for the care of the residents and must be prepared and served as prescribed.

2. Special diets shall be prepared and served as ordered.

3. Nutritional needs must be met in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of the residents.

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

(e) Education programs, including orientation, on-the-job training, inservice education, and continuing education shall be offered to dietetic services personnel on a regular basis.

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

Programs shall include instruction in the use of equipment, personal hygiene, proper inspection, and the handling, preparing, ~~,~~ and serving of food.

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

(g) Menus shall be prepared at least one week in advance. A dietitian shall be consulted to help write and plan the menus. If any change in the actual food served is necessary, the change shall be made on the menu to designate the foods actually served to the residents. Menus of food served shall be kept on file for a thirty (30) day period.

(h) The dietitian or designee shall have a conference, dated on the medical chart, with each resident and/or family within two (2) weeks of admission to discuss the diet plan indicated by the physician. The resident's dietary preferences shall be recorded and utilized in planning his/her daily menu.

(i) Food shall be protected from dust, flies, rodents, unnecessary handling, droplet infection, overhead leakage and other sources of contamination whether in storage or while being prepared and served and/or transported through hallways.

(j) Perishable food shall not be allowed to stand at room temperature except during necessary periods of preparation or serving. Prepared foods shall be kept hot (140°F or above) or cold (45°F or less). Appropriate equipment for temperature maintenance, such as hot and cold serving units or insulated containers, shall be used.

(k) All nursing homes shall have commercial automatic dishwashers approved by the National Sanitation Foundation. Dishwashing machines shall ~~be used according to manufacturer specifications.~~have a hot water supply of one hundred forty degrees Fahrenheit (140° F) to one hundred sixty degrees Fahrenheit (160° F) for washing and one hundred eighty degrees Fahrenheit (180° F) for sanitizing, if within the original design capacity of the machine.

(l) All dishes, glassware and utensils used in the preparation and serving of food and drink shall be cleaned and sanitized after each use.

(m) The cleaning and sanitizing of handwashed dishes shall be accomplished by using a three-compartment sink according to the current "U.S. Public Health Service Sanitation Manual".

(n) The kitchen shall contain sufficient refrigeration equipment and space for the storage of perishable foods.

(o) All refrigerators and freezers shall have thermometers. Refrigerators shall have thermometers. Refrigerators shall be kept at an air temperature not to exceed forty-five degrees Fahrenheit (45° F) whenever food is stored in the unit. Freezers shall be kept at an air temperature sufficient for stored foods to remain frozen, but freezer air temperatures shall never exceed twenty degrees Fahrenheit (20° F).~~Refrigerators shall be kept at a temperature not to exceed 45°F. Freezers shall be kept at a temperature not to exceed 0°F.~~

(p) Written policies and procedures shall be followed concerning the scope of food services in accordance with the current edition of the "U.S. Public Health Service Recommended Ordinance and Code Regulating Eating and Drinking Establishments"

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

and the current "U.S. Public Health Service Sanitation Manual" should be used as a guide to food sanitation.

(10) Social Work Services.

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

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

(c) A resident's social history shall be obtained within two (2) weeks of admission and shall be appropriately maintained.

(d) Social work services shall be provided by a qualified social worker.

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

(11) Physical, Occupational and Speech Therapy Services.

(a) Physical therapy, occupational therapy and speech therapy shall be provided directly or through contractual agreement by individuals who meet the qualifications specified by nursing home policy, consistent with state law.

(b) Speech therapy services shall be provided only by or under supervision of a qualified speech language pathologist in good standing, or by a person qualified as a Clinical Fellow subject to Tennessee Board of Communications Disorders and Sciences Rule 1370-01-.10.

(c) A licensed physical therapist shall be in charge of the physical therapy service and a licensed occupational therapist shall be in charge of the occupational therapy service.

(d) Direct contact shall exist between the resident and the therapist for those residents that require treatment ordered by a physician.

(e) The physical therapist and occupational therapist, pursuant to a physician order, shall provide treatment and training designed to preserve and improve abilities for independent functions, such as: range of motion, strength, tolerance, coordination and activities of daily living.

(f) Therapy services shall be coordinated with the nursing service and made a part of the resident care plan.

(g) Sufficient staff shall be made available to provide the service offered.

(12) Ventilator Services. A nursing home that provides ventilator services shall meet or exceed the following minimum standards by:

(a) Ensuring a licensed respiratory care practitioner as defined by Tennessee Code Annotated Section 63-27-102(7), shall be physically present at the facility twenty four (24) hours per day, seven (7) days per week to provide:

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

1. Ventilator care;

2. Administration of medical gases;

3. Administration of aerosol medications; and

4. Diagnostic testing and monitoring of life support systems;

(b) Ensuring that an appropriate, individualized plan of care is prepared for each patient requiring ventilator services. The plan of care shall be developed with input and participation from a pulmonologist or a physician with experience in ventilator care;

(c) Ensuring that admissions criteria is established to ensure the medical stability of ventilator-dependent patients prior to transfer from an acute care setting;

(d) Ensuring that Arterial Blood Gas (ABG) is readily available in order to document the patient's acid base status and/or End Tidal Carbon Dioxide (etCOs) and whether continuous pulse oximetry measurements should be performed in lieu of ABG studies;

(e) Ensuring that an audible, redundant external alarm system is located outside of each ventilator-dependent patient's room for the purpose of alerting caregivers of patient disconnection, ventilator disconnection or ventilator failure;

(f) Ensuring that the nursing home is equipped with emergency suction equipment and an adequate number of Ambu bags for manual ventilation;

(g) Ensuring that ventilator equipment is connected to electrical outlets connected to back-up generator power;

(h) Ensuring that ventilators are equipped with battery back-up systems;

(i) Ensuring that the nursing home is equipped to employ the use of current ventilator technology consistent with meeting patients' needs for mobility and comfort; and

(j) Ensuring that a back-up ventilator is available at all times.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-3-511, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-216, 68-11-240, 68-11-241, and 68-11-801.* ***Administrative History:*** *Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Amendment filed March 13, 1986; effective April 12, 1986. Amendment filed January 29, 1991; effective March 15, 1991. Amendment filed December 29, 1992; effective February 15, 1993. Amendment filed June 15, 1993; effective July 30, 1993. Amendment filed April 17, 1996; effective July 1, 1996. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed January 31, 2000; effective April 15, 2000. Amendment filed March 29, 2000; effective June 12, 2000. Amendment filed September 13, 2002; effective November 27, 2002. Amendment filed September 4, 2003; effective November 18, 2003. Amendment filed September 21, 2005; effective December 5, 2005. Amendment filed July 18, 2007; effective October 1, 2007. Amendment filed January 3, 2012; effective April 2, 2012. Amendment filed December 16, 2013; effective March 16, 2014. Amendment filed September 15, 2015; effective December 14, 2015. Amendments filed July 18, 2016; effective October 16, 2016. Emergency rule filed February 28, 2018; effective through August 27, 2018. Amendments filed April 19, 2018; effective July 18, 2018. Emergency rules filed May 29, 2020; effective through November 25, 2020. Emergency rules expired effective November 26, 2020, and the rules reverted to their previous statuses.*

1200-08-06-.07 SPECIAL SERVICES: ALZHEIMER'S UNITS. Structurally distinct parts of a nursing home may be designated as special care units for ambulatory residents with dementia or Alzheimer's ~~Disease~~ disease and related disorders. Such units shall be designed to encourage self-sufficiency,

(Rule 1200-08-06-.07, continued)

independence, and decision-making skills, and may admit residents only after the unit is found to be in compliance with licensure standards and upon final approval by the department. Units which hold themselves out to the public as providing specialized Alzheimer's services shall comply with the provisions of T.C.A. § 68-11-1404 and shall be in compliance with the following minimum standards:

(1) In order to be admitted to the special care unit:

(a) A diagnosis of dementia must be made by a physician. The specific etiology causing the dementia shall be identified to the best level of certainty prior to admission to the special care unit; and,

(b) The need for admission must be determined by an interdisciplinary team consisting at least of a physician experienced in the management of residents with Alzheimer's ~~Disease~~ disease and related disorders, a social worker, a registered nurse, and a relative of the resident or a resident care advocate.

(2) Special care units shall be separated from the remaining portion of the nursing home by a locked door and must have extraordinary and acceptable fire safety features and policies which ensure the well-being and protection of the residents.

(3) The residents must have direct access to a secured, therapeutic outdoor area. This outdoor area shall be designed and maintained to facilitate emergency evacuation.

(4) There must be limited access to the designated unit so that visitors and staff do not pass through the unit to get to other areas of the nursing home.

(5) Each unit must contain a designated dining/activity area which shall accommodate 100% seating for residents.

(6) Corridors or open spaces shall be designed to facilitate ambulation and activity, and shall have an unobstructed view from the central working or nurses' station.

(7) Drinking facilities shall be provided in the central working area or nurses' station and in the primary activities areas. Glass front refrigerators may be used.

(8) The unit shall be designed, equipped and maintained to promote positive resident response through the use of:

(a) Reduced-glare lighting, wall and floor coverings, and materials and decorations conducive to appropriate sensory and visual stimulation; and,

(b) Meaningful wandering space shall be provided that encourages physical exercise and ensures that residents will not become frustrated upon reaching dead-ends.

(9) The designated units shall provide a minimum of 3.5 hours of direct care to each resident every day including .75 hours of licensed nursing personnel time. Direct care shall not be limited to nursing personnel time and may include direct care provided by dietary employees, social workers, administrator, therapists and other care givers, including volunteers.

(10) In addition to the classroom instruction required in the nurse aide training program, each nurse aide assigned to the unit shall have forty (40) hours of classroom instruction which shall include but not be limited to the following subject areas:

(a) Basic facts about the causes, progression and management of Alzheimer's Disease and related disorders;

(Rule 1200-08-06-.07, continued)

(b) Dealing with dysfunctional behavior and catastrophic reactions in the resident;

(c) Identifying and alleviating safety risks to the resident;

(d) Providing assistance in the activities of daily living for the resident; and,

(e) Communicating with families and other persons interested in the resident.

(11) Each resident shall have a treatment plan developed, periodically reviewed and implemented by an interdisciplinary treatment team consisting at least of a physician experienced in the management of residents with Alzheimer's Disease and related disorders, a registered nurse, a social worker, an activity coordinator and a relative of the resident or a resident care advocate.

(12) A protocol for identifying and alleviating job related stress among staff on the special care unit must be developed and carried out.

(13) The staff of the unit shall organize a support group for families of residents which meets at least quarterly for the purpose of:

(a) Providing ongoing education for families;

(b) Permitting families to give advice about the operation of the unit;

(c) Alleviating stress in family members; and

(d) Resolving special problems relating to the residents in the unit.

Authority: *T.C.A. §§ 4-5-202, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-1404.* ***Administrative History:*** *Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Repeal and new rule filed January 31, 2000; effective April 15, 2000.*

1200-08-06-.08 BUILDING STANDARDS.

(1) A nursing home shall construct, arrange, and maintain the condition of the physical plant and the overall nursing home environment in such a manner that the safety and well-being of the 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 facilities shall conform to the current edition of the following applicable codes as approved by the Board for Licensing Health Care Facilities: International Building Code (excluding Chapters 1 and 11) including referenced International Fuel Gas Code, International Mechanical Code, and International Plumbing Code; National Fire Protection Association (NFPA) NFPA 101 Life Safety Code excluding referenced NFPA 5000; Guidelines for Design and Construction of Health Care Facilities (FGI) including referenced Codes and Standards; U.S. Public Health Service Food Code; and Americans with Disabilities Act (ADA) Standards for Accessible Design. When referring to height, area or construction type, the International Building Code shall prevail. Where there are conflicts between requirements in local codes, the above listed codes, regulations and provisions of this chapter, the most stringent requirements shall apply.

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

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

(4) The licensed contractor shall perform all new construction and renovations to nursing homes, 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 nursing homes, including the submission of phased construction plans and the final drawings and the specifications to each.

(5) No new nursing home shall be constructed, nor shall major alterations be made to an existing nursing home without prior written approval of the department, and unless in accordance with plans and specifications approved in advance by the department. Before any new nursing home is licensed or before any alteration or expansion of a licensed nursing home 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 where applicable:

(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;

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

(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 where applicable:

(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 where applicable:

(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 where applicable:

(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;

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

(c) An electrical system that complies with applicable codes;

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

(e) Circuit breakers that are properly labeled; and

(f) Ground-Fault Circuit Interrupters (GFCI) that are required in all wet areas, such as kitchens, laundries, janitor closets, bath and toilet rooms, etc, and within six (6) feet of any lavatory.

(14) The electrical drawings shall not include knob and tube wiring, shall not include electrical cords that have splices, and shall not show that the electrical system is overloaded.

(15) In all new facilities or renovations to existing electrical systems, the installation must be approved by an inspector or agency authorized by the State Fire Marshal.

(16) Sprinkler drawings shall include where applicable:

(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.

(17) 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 nursing home 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 and bathing facilities shall not exceed one hundred twenty degrees Fahrenheit (120°F).

~~Hot water at shower, bathing and hand washing facilities shall be between 105°F and 115°F.~~

(18) It shall be demonstrated through the submission of plans and specifications that in each nursing home 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.

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

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

(20) In the event submitted materials do not appear to satisfactorily comply with 1200-08-06-.08(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.

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

(22) 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 1200-08-06-.08(2). 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.

(23) Prior to final inspection, a CD Rom disc, in TIF or PDF format, of the final approved plans including all shop drawings, sprinkler, calculations, hood and duct, addenda, specifications, etc., shall be submitted to the department.

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

(a) Fire alarms;

(b) Generators (if applicable); and

(c) Medical gas alarms (if applicable).

(25) Each nursing home shall ensure that an emergency keyed lock box is installed next to each bank of functioning elevators located on the main level. Such lock boxes shall be permanently mounted seventy-two inches (72") from the floor to the center of the box, be operable by a universal key no matter where such box is located, and shall contain only fire service keys and drop keys to the appropriate elevators.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-57, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-261.* ***Administrative History:*** *Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Amendment filed July 3, 1984; effective August 1, 1984. Amendment filed March 13, 1986; effective April 12, 1986. Amendment filed October 22, 1987; effective December 6, 1987. Amendment filed February 11, 1992; effective March 27, 1992. Amendment filed January 6, 1995; effective March 22, 1995. Amendment filed June 13, 1997; effective August 27, 1997. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed February 18, 2003; effective May 4, 2003. Repeal and new rule filed September 21, 2005; effective December 5, 2005. Amendment filed February 23, 2007; effective May 9, 2007. Repeal and new rule filed December 20, 2011; effective March 19, 2012. Amendment filed January 21, 2016; effective April 20, 2016.*

1200-08-06-.09 LIFE SAFETY.

(1) Any nursing home which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.

(2) The nursing home shall provide fire protection by the elimination of fire hazards, by the installation of necessary fire-fighting equipment and by the adoption of a written fire control plan. Fire drills shall be held at least quarterly for each work shift for nursing home personnel in each separate patient-occupied nursing home building. There shall be a written report

(Rule 1200-08-06-.09, continued)

documenting the evaluation of each drill and the action recommended or taken for any deficiencies found. Records which document and evaluate these drills must be maintained for at least three (3) years. All fires which result in a response by the local fire department shall be reported to the department within seven (7) days. The report shall contain sufficient information to ascertain the nature and location of the fire, its probable cause and any injuries incurred by any person or persons as a result of the fire. Initial reports by the facility may omit the name(s) of resident(s) and parties involved, however, should the department find the identities of such per

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.* ***Administrative History:*** *Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Repeal and new rule filed September 21, 2005; effective December 5, 2005.*

1200-08-06-.10 INFECTIOUS AND HAZARDOUS WASTE.

(1) Each nursing home must develop, maintain and implement written policies and procedures for the definition and handling of its infectious and hazardous wastes. These policies and procedures must comply with the standards of this section and all other applicable state and federal regulations.

(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, waste from the production of biologicals, discarded live and attenuated vaccines, 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) 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; or,

(e) Other waste determined to be infectious by the facility 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 facility.

(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 preserving the integrity of the packaging, including the use of secondary containment where necessary.

(a) Infectious waste must not be compacted or ground (i.e., in a mechanical grinder) prior to treatment, except that pathological waste may be ground prior to disposal.

(b) 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. 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.

(7) In the event of spills, ruptured packaging, or other incidents where there is a loss of containment of waste, the facility 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 this rule;

(c) Sanitize all contaminated equipment and surfaces appropriately. Written policies and procedures must specify how this will be done; 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) A facility 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 conditions were met for proper sterilization or disinfection of materials included in the cycle, and records kept. Proper operation of such devices must be verified at least monthly, and records of these monthly checks 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

(Rule 1200-08-06-.10, continued)

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) The facility 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) The facility 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 in Tennessee, the facility 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 in another state, the facility must notify in writing all public health agencies with jurisdiction that the location is being used for management of the facility'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) All garbage, trash and other non-infectious waste shall be stored and disposed of in a manner that shall 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. §§ 4-5-202, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.* ***Administrative History:*** *Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Amendment filed July 3, 1984; effective August 1, 1984. Amendment filed March 13, 1986; effective April 12, 1986. Amendment filed October 22, 1987; effective December 6, 1987. Amendment filed February 11, 1992; effective March 27, 1992. Amendment filed January 6, 1995; effective March 22, 1995. Amendment filed June 13, 1997; effective August 27, 1997. Repeal and new rule filed January 31, 2000; effective April 15, 2000.*

1200-08-06-.11 RECORDS AND REPORTS.

(1) The nursing home shall report each case of communicable disease to the local county health officer in the manner provided by existing regulations. Failure to report a communicable disease may result in disciplinary action, including revocation of the facility's license.

(2) The nursing home shall report all incidents of abuse, neglect, and misappropriation to the Department of Health in accordance with T.C.A. § 68-11-211.

(3) The nursing home shall report the following incidents to the Department of Health in accordance with T.C.A. § 68-11-211.

(a) Strike by staff at the facility;

(b) External disasters impacting the facility;

(Rule 1200-08-06-.11, continued)

(c) Disruption of any service vital to the continued safe operation of the nursing home or to the health and safety of its patients and personnel; and

(d) Fires at the nursing home that disrupt the provision of patient care services or cause harm to the patients or staff, or that are reported by the facility to any entity, including but not limited to a fire department charged with preventing fires.

(4) The nursing home shall retain legible copies of the following records and reports for thirty-six months following their issuance. They shall be maintained in a single file and shall be made available for inspection during normal business hours to any person who requests to view them:

(a) Local fire safety inspections;

(b) Local building code inspections, if any;

(c) Fire marshal reports;

(d) Department licensure and fire safety inspections and surveys;

(e) Federal Health Care Financing Administration surveys and inspections, if any;

(f) Orders of the Commissioner or Board, if any;

(g) Comptroller of the Treasury's audit reports and findings, if any; and,

(h) Maintenance records of all safety and patient care equipment.

1. Routine maintenance shall be administered according to the manufacture's recommended maintenance for the above equipment.

2. Ensure that facility staff or contract personnel are appropriately trained to conduct safety and patient care equipment inspections.

(5) A yearly statistical report, the "Joint Annual Report of Nursing Homes", shall be submitted to the Department. The forms are mailed to each nursing home by the Department each year. The forms shall be completed and returned to the Department as requested.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, and 68-11-804.* ***Administrative History:*** *Original rule filed March 27, 1975; effective April 25, 1997. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Amendment filed March 13, 1986; effective April 12, 1986. Amendment filed December 29, 1993; effective February 15, 1993. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed September 4, 2003; effective November 18, 2003. Amendment filed April 17, 2007; effective July 1, 2007. Amendments filed January 3, 2012; effective April 2, 2012.*

1200-08-06-.12 RESIDENT RIGHTS.

(1) The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Residents and their families or other representatives shall be fully informed and documentation shall be maintained in the resident's file of the following rights:

(a) To privacy in treatment and personal care;

(Rule 1200-08-06-.12, continued)

(b) To privacy, if married, for visits by his/her spouse;

(c) To share a room with his/her spouse (if both are residents);

(d) To be different, in order to promote social, religious and psychological well-being;

(e) To privately talk and/or meet with and see anyone;

(f) To send and receive mail promptly and unopened;

(g) To be free from mental and physical abuse. Should this right be violated, the facility must notify the department within five (5) working days. The Tennessee Department of Human Services, Adult Protective Services shall be notified immediately as required in T.C.A. § 71-6-103;

(h) To be free from chemical and physical restraints;

(i) To meet with members of and take part in activities of social, commercial, religious and community groups. The administrator may refuse access to the facility to any person if that person's presence would be injurious to the health and safety of a resident or staff, or would threaten the security of the property of the resident, staff or facility;

(j) To form and attend resident council meetings. The facility shall provide space for meetings and reasonable assistance to the council when requested;

(k) To retain and use personal clothing and possessions as space permits;

(l) To be free from being required by the facility to work or perform services;

(m) To be fully informed by a physician of his/her health and medical condition. The facility shall give the resident and family the opportunity to participate in planning the resident's care and medical treatment;

(n) To refuse treatment. The resident must be informed of the consequences of that decision. The refusal and its reason must be reported to the physician and documented in the medical record;

(o) To refuse experimental treatment and drugs. The resident's or health care decision maker's written consent for participation in research must be obtained and retained in his or her medical record;

(p) To have their records kept confidential and private. Written consent by the resident must be obtained prior to release of information except to persons authorized by law. If the resident lacks capacity, written consent is required from the resident's health care decision maker. The nursing home must have policies to govern access and duplication of the resident's record;

(q) To manage personal financial affairs. Any request by the resident for assistance must be in writing. A request for any additional person to have access to a resident's funds must also be in writing;

(r) To be told in writing before or at the time of admission about the services available in the facility and about any extra charges, charges for services not covered under Medicare or Medicaid, or not included in the facility's bill;

(Rule 1200-08-06-.12, continued)

(s) To be free from discrimination because of the exercise of the right to speak and voice complaints;

(t) To exercise his/her own independent judgment by executing any documents, including admission forms;

(u) To have a free choice of providers of medical services, such as physician and pharmacy. However, medications must be supplied in packaging consistent with the medication system of the nursing home;

(v) To be free from involuntary transfer or discharge, except for these reasons:

1. Medical reasons;

2. His/her welfare or that of the other residents; or

3. Nonpayment, except as prohibited by the Medicaid program;

(w) To voice grievances and complaints, and to recommend changes in policies and services to the facility staff or outside representatives of the resident's choice. The facility shall establish a grievance procedure and fully inform all residents and family members or other representatives of the procedure;

(x) To have appropriate assessment and management of pain; and

(y) To be involved in the decision making of all aspects of their care.

(2) The rights set forth in this section may be abridged, restricted, limited or amended only as follows:

(a) When medically contraindicated;

(b) When necessary to protect and preserve the rights of other residents in the facility; or

(c) When contradicted by the explicit provisions of another rule of the board.

(3) Any reduction in residents' rights based upon medical consideration or the rights of other residents must be explicit, reasonable, appropriate to the justification, and the least restrictive response feasible. They may be time-limited, shall be explained to the resident, and must be documented in the individual resident's record by reciting the limitation's reason and scope. Medical contraindications shall be supported by a physician's order. At least once each month, the administrator and the director of nursing shall review the restriction's justification and scope before removing it, amending it, or renewing it. The names of any residents in the facility whose rights have been restricted under the provisions of this rule shall be maintained on a separate list which shall be available for inspection by the department and by the area long-term care ombudsman.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-901, and 68-11-902.* ***Administrative History:*** *Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Amendment filed May 24, 2985; effective June 23, 1985. Amendment filed March 13, 1986; effective April 12, 1986. Amendment filed October 22, 1987; effective December 6, 1987. Amendment filed May 10, 1990; effective June 24, 1990. Amendment filed March 9, 1992; effective April 23, 1992. Amendment filed March 10, 1995; effective May 24, 1995. Amendment filed June 13, 1997; effective August 27, 1997. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed June 18, 2002; effective September 1, 2002. Amendment filed September 21, 2005; effective December 5, 2005.*

1200-08-06-.13 POLICIES AND PROCEDURES FOR HEALTH CARE DECISION-MAKING.

(1) Pursuant to this Rule, each nursing home 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 may limit the power of the agent, and may include individual instructions. The effect of an advance directive that makes no limitation on the agent's authority shall be to 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 estate of the resident upon the death of the resident. 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 authority of an agent becomes effective only upon a determination that the resident lacks capacity, and ceases to be effective upon a determination that the resident has recovered capacity.

(5) A facility may use any advanced directive form that meets the requirements of the Tennessee Health Care Decisions Act or has been developed and issued by the Board for Licensing Health Care Facilities.

(6) A determination that a resident lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent shall be made by the designated physician, who is authorized to consult with such other persons as he or she 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) A health care facility 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

(Rule 1200-08-06-.13, continued)

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 an 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 an earlier 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 the supervising health care provider. The designation may be oral or written.

(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 resident has been determined by the designated physician to lack capacity, and

2. No agent or guardian has been appointed, or

3. The agent or guardian is not reasonably available.

(c) In the case of a resident who lacks capacity, the resident's surrogate shall be identified by the supervising health care provider and documented in the current clinical record of the facility at which the resident is receiving health care.

(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 1200-08-06-.13(16)(d).

(Rule 1200-08-06-.13, continued)

(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 known wishes of the resident or in accordance with the resident's 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 1200-08-06-.13(16)(c) through 1200-08-06-.13(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 to the surrogate.

(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.

(Rule 1200-08-06-.13, continued)

(l) Except as provided in 1200-08-06-.13(16)(m):

1. Neither the treating health care provider nor an employee of the treating health care provider, nor an operator of a health care institution nor an employee of an operator of a health care institution may be designated as a surrogate; 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) An employee of the treating health care provider or an employee of an operator of a health care institution may be designated as a surrogate 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 the 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 1200-08-06-.13(20) through 1200-08-06-.13(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 a policy of the institution which is based on reasons of conscience, and

(b) The policy was timely communicated 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 1200-08-06-.13(20) through 1200-08-06-.13(22) shall:

(a) Promptly so inform the resident, if possible, and any person then authorized to make health care decisions for the resident;

(b) Provide continuing care to the resident until a transfer can be effected or until the determination has been made that transfer cannot be effected;

(c) Unless the resident or person then authorized to make health care decisions for the resident refuses assistance, 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; 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 for such identification 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.

(Rule 1200-08-06-.13, continued)

(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) Physician Orders for Scope of Treatment (POST)

(a) Physician Orders for Scope of Treatment (POST) may be issued by a physician for a patient with whom the physician has a bona fide physician-patient relationship, but only:

1. With the informed consent of the patient;

2. If the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon 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, if the physician determines that the provision of cardio pulmonary resuscitation would be contrary to accepted medical standards.

(b) A POST may be issued by a physician assistant, nurse practitioner or clinical nurse specialist for a patient with whom such physician assistant, nurse practitioner or clinical nurse specialist has a bona fide physician assistant-patient or nurse-patient relationship, but only if:

1. No physician, who has a bona fide physician-patient relationship with the patient, is present and available for discussion with the patient (or if the patient is a minor or is otherwise incapable of making an informed decision, with the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act);

2. Such authority to issue is contained in the physician assistant's, nurse practitioner's or clinical nurse specialist's protocols;

3. Either:

(i) The patient is a resident of a nursing home licensed under title 68 or an ICF/MR facility licensed under title 33 and is in the process of being discharged from the nursing home or transferred to another facility at the time the POST is being issued; or

(ii) The patient is a hospital patient and is in the process of being discharged from the hospital or transferred to another facility at the time the POST is being issued; and

4. Either:

(i) With the informed consent of the patient;

(ii) If the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon request of and with the

(Rule 1200-08-06-.13, continued)

consent of the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act; or

(iii) 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 and such authority to issue is contained in the physician assistant, nurse practitioner or clinical nurse specialist's protocols and the physician assistant or nurse determines that the provision of cardiopulmonary resuscitation would be contrary to accepted medical standards.

(c) If the patient is an adult who is capable of making an informed decision, the patient's expression of the desire to be resuscitated in the event of cardiac or respiratory arrest shall revoke any contrary order in the POST. If the patient is a minor or is otherwise incapable of making an informed decision, the expression of the desire that the patient be resuscitated by the person authorized to consent on the patient's behalf shall revoke any contrary order in the POST. Nothing in this section shall be construed to require cardiopulmonary resuscitation of a patient for whom the physician or physician assistant or nurse practitioner or clinical nurse specialist determines cardiopulmonary resuscitation is not medically appropriate.

(d) A POST issued in accordance with this section shall remain valid and in effect until revoked. In accordance with this rule and applicable regulations, 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, the Department of Mental Health and Substance Abuse Services, or the Department of Intellectual and Developmental Disabilities, or operated, licensed, or owned by another state agency, shall follow a POST that is available to such persons in a form approved by the Board for Licensing Health Care Facilities.

(e) Nothing in these rules shall authorize the withholding of other medical interventions, such as medications, positioning, wound care, oxygen, suction, treatment of airway obstruction or other therapies deemed necessary to provide comfort care or alleviate pain.

(f) If a person has a do-not-resuscitate order in effect at the time of such person's discharge from a health care facility, the facility shall complete a POST prior to discharge. If a person with a POST 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 POST to qualified emergency medical service personnel and to the receiving facility prior to the transfer. The transferring facility shall provide a copy of the POST that accompanies the patient in transport to the receiving health care facility. Upon admission, the receiving facility shall make the POST a part of the patient's record.

(g) These rules shall not prevent, prohibit, or limit a physician from using a written order, other than a POST, not to resuscitate a patient in the event of cardiac or respiratory arrest in accordance with accepted medical practices. This action shall have no application to any do not resuscitate order that is not a POST, as defined in these rules.

(h) Valid do not resuscitate orders or emergency medical services do not resuscitate orders issued before July 1, 2004, pursuant to then-current law, shall remain valid and shall be given effect as provided in these rules.

(Rule 1200-08-06-.13, continued)

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-224, and 68-11-1801 through 68-11-1815.* ***Administrative History:*** *Original rule filed June 22, 1992; effective August 6, 1992. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed April 28, 2003; effective July 12, 2003. Repeal and new rule filed September 21, 2005; effective December 5, 2005. Amendment filed February 7, 2007; effective April 23, 2007. Amendments filed January 3, 2012; effective April 2, 2012. Amendment filed March 27, 2015; effective June 25, 2015.*

1200-08-06-.14 DISASTER PREPAREDNESS.

(1) Emergency Electrical Power.

(a) All nursing homes must have one or more on-site electrical generators which are capable of providing emergency electrical power to at least all life sustaining equipment and life sustaining resources such as: ventilators, blood banks, biological refrigerators, safety switches for boilers, safety lighting for corridors and stairwells, and other essential equipment.

(b) Connections shall be through a switch which shall automatically transfer the circuits to the emergency power source in case of power failure. It is recognized that some equipment may not sustain automatic transfer and provisions will have to be made to manually change these items from a non-emergency powered outlet to an emergency powered outlet or other power source. All emergency power transfer switches shall be labeled as such. Switches affecting heat, ventilation, and all systems shall be labeled.

(c) The emergency power system shall have a minimum of twenty four (24) hours of either propane, gasoline or diesel fuel. The quantity shall be based on its expected or known connected load consumption during power interruptions. In addition, the nursing home shall have a written contract with an area fuel distributor which guarantees first priority service for re-fills during power interruptions.

(d) The emergency power system (generator) shall be inspected weekly and exercised under actual load and operating temperature conditions for at least thirty (30) minutes, once each month, including automatic and manual transfer of equipment. The generator shall be exercised by trained facility staff who are familiar with the systems operation. Instructions for the operation of the systems and the manual transfer of emergency power shall be maintained with the facility's disaster preparedness plan and shall be separately identified in the plan. Records shall be maintained for all weekly inspections and monthly tests and be kept on file for a minimum of three (3) years.

(2) Physical Facility and Community Emergency Plans.

(a) Physical Facility (Internal Situations).

1. Every nursing home shall have a current internal emergency plan, or plans, that provides for fires, bomb threats, severe weather, utility service failures, plus any local high risk situations such as floods, earthquakes, toxic fumes and chemical spills. The plan should consider the probability of the types of disasters which might occur, both natural and "man-made".

2. The plan(s) must include provisions for the relocation of persons within the building and/or either partial or full building evacuation. Facilities which do not have sufficient emergency generator capacity to provide a place of refuge for residents during severe hot or cold weather emergencies shall specifically establish an emergency plan to assure a common area (dining room, hallway, or day rooms) is heated or cooled sufficiently to sustain residents during an emergency. This can be accomplished through several approaches including the

(Rule 1200-08-06-.14, continued)

installation of a transfer switch at the facility to which an emergency generator may be connected to operate a HVAC system for the place of refuge, or transportation of a generator to the facility and direct connection from the generator to emergency portable heating or cooling units. The plan must be coordinated with local emergency management agencies that provide emergency generators or heating or cooling units; and facilities are encouraged to enter into private agreements with local generator suppliers, rental agencies or other reliable sources of emergency power. Plans that provide for the relocation of residents to other health care facilities must have written agreements for emergency transfers. The agreements may be mutual, i.e. providing for transfers either way.

3. Copies of the plan(s), either complete or outlines, including specific emergency telephone numbers related to that type of disaster, shall be available to all staff. A copy shall be readily available at all times in the telephone operator's position or at the security center. Provisions that have security implications may be omitted from the outline versions. Familiarization information shall be included in employee orientation sessions and more detailed instructions must be included in continuing education programs. Records of orientation and education programs must be maintained for at least three (3) years.

4. The plan must provide for additional staffing, medical supplies, blood and other resources which would probably be needed.

5. Each of the following disaster preparedness plans shall be conducted annually prior to the month listed in the plan. Drills are for the purpose of educating staff, resource determination, testing personnel safety provisions and communications with other facilities and community agencies. Records which document and evaluate these drills must be maintained for at least three (3) years.

   (i) Fire Safety Procedures Plan, to be exercised at any time during the year, shall include:

      (I) Minor fires;

      (II) Major fires;

      (III) Fighting the fire;

      (IV) Evacuation procedures;

      (V) Staff functions by department and job assignment; and,

      (VI) Fire drill schedules (fire drills shall be held at least quarterly on each work shift).

   (ii) External disaster procedures plan (for tornado, flood, earthquake), to be exercised prior to March, shall include:

      (I) Staff duties by department and job assignment; and,

      (II) Evacuation procedures.

   (iii) Bomb Threat Procedures Plan, to be exercised at any time during the year:

      (I) Staff duties by department and job assignment; and,

(II) Search team, searching the premises.

6. The nursing home shall develop and periodically review with all employees a prearranged plan for the orderly evacuation of all residents in case of a fire, internal disaster or other emergency. The plan of evacuation shall be posted throughout the home. Fire drills shall be held at least quarterly for each work shift for nursing home personnel in each separate patient-occupied nursing home building. There shall be a written report documenting the evaluation of each drill and the action recommended or taken for any deficiencies found. Records which document and evaluate these drills must be maintained for at least three (3) years.

(b) Community Emergency (Mass Casualty).

1. Every nursing home, unless exempted due to its limited scope of clinical services, shall have a plan that provides for the reception and treatment, within its capabilities, of medical emergencies resulting from a disaster within its usual service area. The plan should consider the probability of the types of disasters which might occur, both natural and “man-made”.

2. The plan must provide for additional staffing, medical supplies, blood and other resources which would probably be needed. The plan must also provide for the deferral of elective admission patients and also for the early transfer or discharge of some current patients if it appears that the number of casualties will exceed available staffed beds.

3. Copies of the plan(s), either complete or outlines, including specific emergency telephone numbers related to that type of disaster, shall be available to staff who would be assigned non-routine duties during these types of emergencies. Familiarization information shall be included in employee orientation sessions and more detailed instruction must be included in continuing education programs. Records of orientation and education must be maintained for at least three (3) years.

4. At least one drill shall be conducted each year for the purpose of educating staff, resource determination, and communications with other facilities and community agencies. Records which document and evaluate these drills must be maintained for at least three (3) years.

5. As soon as possible, actual community emergency situations that result in the treatment of more than twenty (20) patients, or fifteen percent (15%) of the licensed bed capacity, whichever is less, must be documented. Actual situations that had education and training value may be substituted for a drill. This includes documented actual plan activation during community emergencies, even if no patients are received.

(c) Emergency Planning with Local Government Authorities.

1. All nursing homes shall establish and maintain communications with the county Emergency Management Agency. This includes the provision of the information and procedures that are needed for the local comprehensive emergency plan. The facility shall cooperate, to the extent possible, in area disaster drills and local emergency situations.

(Rule 1200-08-06-.14, continued)

2. Each nursing home must rehearse both the Physical Facility and Community Emergency plan as required in this rule, even if the local Emergency Management Agency is unable to participate.

3. A file of documents demonstrating communications and cooperation with the local agency must be maintained.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed September 21, 2005; effective December 5, 2005.*

1200-08-06-.15 NURSE AIDE TRAINING AND COMPETENCY EVALUATION. All nurse aide training programs must comply with the federal nurse aide training and competency regulations, promulgated pursuant to the Omnibus Budget Reconciliation Act of 1987, and with federal labor laws, including but not limited to minimum age requirements. Copies of these regulations may be obtained from the department.

(1) Testing service.

(a) The Department shall provide or contract for the provision of nurse aide testing services as follows:

1. Annual publication of testing schedules and sites.

2. Test sites shall be located so that no individual is required to drive farther than thirty (30) miles to reach a test site.

3. Scheduled tests shall be administered, except when no individual is scheduled to test at a particular test site.

4. The number of individuals passing and failing shall be published following each test.

5. The minimum passing grade for each test shall be seventy-five percent (75%) for the written or oral component**.** The performance demonstration portion of the test shall consist, at minimum, of five performance tasks, which shall be selected randomly for each registrant from a pool of skills evaluation tasks ranked according to degree of difficulty, with at least one task selected from each degree of difficulty. Registrants are required to pass a minimum of five (5) performance tasks.

6. Individuals who fail any portion of the test three (3) consecutive times shall repeat training prior to taking the test again.

(b) Applications to take the test shall be sent by the program coordinator to the appropriate testing agency postmarked no later than thirty (30) days prior to the test date. Requests for special testing needs shall be made to the testing agency at this time.

(c) The department shall provide the board with quarterly reports on the number of individuals passing and failing each test.

(d) A practical and written test will be developed to reflect that a trainee has acquired the minimum competency skills necessary to become a competent and qualified nurse aide. The Nurse Aide Advisory Committee, composed of twelve (12) members with at least three (3) members nominated by the Tennessee Health Care Association, will

(Rule 1200-08-06-.15, continued)

periodically review testing materials and set criteria for survey visits of the nurse aide programs.

(e) The test will be developed from a pool of questions, only a portion of which is to be used for grading purposes in any one test, not to exceed one hundred (100) questions. A system must be developed which prevents the disclosure of the pool of questions and of the performance demonstration portion of the test.

(2) Training program.

(a) Requests for approval of a nurse aide training program shall be submitted to the department and shall include the following:

1. Name, address and telephone number of the facility, institution or agency offering the program;

2. The program coordinator's name, address, license number and verification of a minimum of two (2) years nursing experience, at least one of which must be in the provision of long-term care facility services;

3. Statement of course objectives;

4. Description of course content specifying the number of hours to be spent in the classroom and in clinical settings; and,

5. In lieu of (3) and (4) above, the fact that the curriculum is previously department-approved.

(b) Notification of any change to any one of the above five (5) items or termination of the program must be submitted to the department within 30 days.

(c) Each training program shall have a pass rate on both written and performance exams of at least 70%. Annual reviews of Nurse Aide Training Programs shall include:

1. Letter of commendation for exceptional pass rate as evaluated by the department;

2. Letter of concern for programs having one year of test pass rates below 70%;

3. Request for plan of program improvement for programs with two consecutive years of test pass rates below 70%;

4. After the third year of consecutive test pass rates below seventy-percent (70%), the program shall be closed for no less than twenty-four (24) months. All students enrolled in the program shall be allowed to complete the course. Any program closed may appeal the closure to the Board pursuant to the Uniform Administrative Procedures Act compiled in Title 4, Chapter 5, Part 3.

(d) Each program coordinator shall be responsible for ensuring that the following requirements are met:

1. Course objectives are accomplished;

2. Only persons having appropriate skills and knowledge are selected to conduct any part of the training;

(Rule 1200-08-06-.15, continued)

3. The provision of direct individual care to residents by a trainee is limited to appropriately supervised clinical experiences; a program instructor must be present or readily available on-site during all clinical training hours including direct patient care for the seventy-five (75) hour training program. All activities of daily living (ADL) skills, including but not limited to bathing, feeding, toileting, grooming, oral care, and perineal care, must be taught prior to student performing direct patient care;

4. The area used for training is well-lighted, well-ventilated and provides for privacy for instruction. Such requirements are not to exceed the requirements for physical space in a nursing facility;

5. Each trainee demonstrates competence in clinical skills and fundamental principles of resident care;

6. Records are kept to verify the participation and performance of each trainee in each phase of the training program. The satisfactory completion of the training program by each trainee shall be attested to on each trainee's record;

7. Each trainee is issued a certificate of completion which includes at least the name of the program, the date of issuance, the trainee's name and the signature of the program coordinator.

8. The program coordinator shall be responsible for the completion, signing and submission to the department of all required documentation.

(e) Student to teacher ratio must be as follows: 25:1 in classroom and 15:1 for direct patient care training.

(3) Nurse Aide Registry. A nursing home must not use any individual working in a facility as a nurse aide for more than four (4) months unless that individual's name is included on the Nurse Aide Registry. A facility must not use on a temporary, per diem, leased or any basis other than permanent, any individual who does not meet the requirements of training and competency testing.

(a) The nurse aide registry shall include:

1. The individual's full name, including a maiden name and any other surnames used;

2. The individual's last known home address;

3. The individual's date of birth; and,

4. The date that the individual passed the competency test and the expiration date of the individual's current registration.

(b) The name of any individual who has not performed nursing or nursing related services for a period of twenty-four (24) consecutive months shall be removed from the Nurse Aide Registry.

(4) Continued Competency. The facility must complete a performance review of each nurse aide employee at least once every 12 months and must provide regular in-service education based on the outcome of these reviews. Each nurse aide must receive at least ten (10) hours of training each year, and a record verifying attendance shall be kept in the nursing home files.

(Rule 1200-08-06-.15, continued)

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, and 68-11-804.* ***Administrative History:*** *Original rule filed September 4, 2003; effective November 18, 2003. Amendment filed March 27, 2015; effective June 25, 2015..*

1200-08-06-.16 APPENDIX I

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

Tennessee Physician Orders for Scope of Treatment (POST, sometimes called "POLST") 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 is not breathing.** ☐ **Resuscitate(CPR)** ☐ **Do Not Attempt Resuscitation (DNR / no CPR) (Allow Natural Death)** 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 Only.** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. 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. Treatment Plan: Maximize comfort through symptom management.** ☐ **Limited Additional Interventions.** In addition to care described in Comfort Measures Only above, use medical treatment, antibiotics, IV fluids and cardiac monitoring as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). **Transfer** to hospital if indicated. Generally avoid the intensive care unit. **Treatment Plan: basic medical treatments.** ☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. **Transfer** to hospital and/or intensive care unit if indicated. **Treatment Plan: Full treatment including in the intensive care unit.** *Other Instructions:*_____
Section C *Check One*	**ARTIFICIALLY ADMINISTERED NUTRITION. Oral fluids & nutrition must be offered if feasible.** ☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube. ☐ Long-term artificial nutrition by tube. *Other Instructions:*_____

(Rule 1200-08-06-.16, continued)

Section D *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/NP/CNS/PA Name (Print)	**Physician/NP/CNS/PA Signature Date** NP/CNS/PA (Signature at Discharge)	**MD/NP/CNS/PA Phone Number:**

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

Preferences have been expressed to a physician and/or health care professional. It can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

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

Agent/Surrogate	Relationship	Phone Number

Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

(Rule 1200-08-06-.16, continued)

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.

To be valid, POST must be signed by a physician or, at discharge or transfer from a hospital or long term care facility, by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Persons with DNR in effect at time of discharge must have POST completed by health care facility prior to discharge and copy of POST provided to qualified medical emergency personnel.

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 Health Care Agent or 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 D and write “VOID” in large letters if POST is replaced or becomes invalid.

(Rule 1200-08-06-.16, continued)

(2) Advance Directive for Health Care Form

ADVANCE DIRECTIVE FOR HEALTH CARE*
(Tennessee)

Instructions: Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

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.

Part I Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____Home Phone: _____Work Phone: _____
Address: _____Mobile Phone: _____Other Phone: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____Home Phone: _____Work Phone: _____
Address: _____Mobile Phone: _____Other Phone: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Part 2 Indicate Your Wishes for Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**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.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Indicate Your Wishes for Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

(Rule 1200-08-06-.16, continued)

☐ 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 a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Part 3 **Other instructions, such as hospice care, burial arrangements, etc.:** _____

_____

_____

_____

_____

_____

_____

_____

(Attach additional pages if necessary)

Part 4 **Organ donation:** Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

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

_____

☐ No organ/tissue donation

SIGNATURE

Part 5 Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: _____ Date: _____
(Patient)

_____

Block A Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent or alternate. 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 or alternate. 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

_____

Block B You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE
COUNTY OF _____

(Rule 1200-08-06-.16, continued)

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: (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.* ***Administrative History:*** *Original rule filed February 16, 2007; effective May 2, 2007. Repeal and new rule filed August 28, 2012; effective November 26, 2012. Amendment filed March 27, 2015; effective June 25, 2015. Amendments filed February 8, 2017; effective May 9, 2017.*

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

CHAPTER 1200-08-10
STANDARDS FOR AMBULATORY SURGICAL TREATMENT CENTERS

TABLE OF CONTENTS

1200-08-10-.01 DEFINITIONS.

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

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

(a) How the deficiency will be corrected.

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

(c) The date the deficiency will be corrected.

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

(3) Accredited Record Technician (ART). A person currently accredited as such by the American Medical Records Association.

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

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

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

(7) Ambulatory surgical treatment center (ASTC). Any institution, place or building devoted primarily to the maintenance and operation of a facility for the performance of surgical procedures. Such facilities shall not provide beds or other accommodations for the stay of a patient to exceed twelve (12) hours duration, provided that the length of stay may be extended for an additional twelve (12) hours in the event such stay is deemed necessary by the attending physician, the facility medical director, or the anesthesiologist for observation or recovery, but in no event shall the length of stay exceed twenty-four (24) hours. Individual patients shall be discharged in an ambulatory condition without danger to the continued well-

(Rule 1200-08-10-.01, continued)

being of the patients or shall be transferred to a hospital. Excluded from this definition are the private physicians' and dentists' office practices. For the purposes of this rule, those medical and dental offices, facilities, and other settings at which surgical procedures exclusively are performed are ASTC's and not private office practices. Surgical procedures that generally result in extensive blood loss, require major or prolonged invasion of body cavities, or are considered emergency or life-threatening in nature may not be performed.

~~ASTC's must comply with the following for purposes of these regulations:~~

~~(a) Surgical procedures performed must be limited to those procedures which are commonly performed on an inpatient basis in hospitals but may safely be performed in an ASTC;~~

~~(b) If anesthesia is required for a surgical procedure, it must be local, regional or general anesthesia and routinely be four (4) hours or less in duration;~~

~~(c) Surgical procedures that generally result in extensive blood loss, require major or prolonged invasion of body cavities, or are considered emergency or life-threatening in nature may not be performed.~~

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

(9) Cancer Treatment and Radiation Clinic. A facility in which the only procedures performed are diagnostic and therapeutic radiology, chemotherapy and related services.

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

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

(12) Central Services Department. A department within a healthcare facility that processes, issues, and controls medical supplies, devices and equipment, both sterile and nonsterile, for patient care areas of a healthcare institution.

(13) Central Services Technician. A person who decontaminates, inspects, assembles, packages, and sterilizes reusable medical instruments or devices in a healthcare institution, whether such person is employed by the healthcare institution or provides services pursuant to a contract with the healthcare institution.

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

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(Rule 1200-08-10-.01, continued)

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

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

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

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

(197) Competent. A patient who has capacity.

(2018) Dentist. A person currently licensed as such by the Tennessee Board of Dentistry.

(2119) Department. The Tennessee Department of Health.

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

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

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

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

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

(275) Gastrointestinal Endoscopy Clinic. A facility in which the only procedures performed are those related to the gastrointestinal tract and other endoscopic procedures. This excludes laparoscopy and limits entry to major body cavities by needle aspiration only.

(286) General Anesthesia. An induced state of unconsciousness accompanied by partial or complete loss of protective reflexes inducing the inability to continually maintain an airway independently and respond purposefully to physical stimulation or verbal command, and produced by a pharmacological or non-pharmacological method or a combination thereof.

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

(Rule 1200-08-10-.01, continued)

(30~~28~~) Guardian. A judicially appointed guardian or conservator having authority to make a health care decision for an individual.

(31~~29~~) Hazardous Waste. Materials whose handling, use, storage and disposal are governed by local, state or federal regulations.

(32~~0~~) Health Care. Any care, treatment, service or procedure to maintain, diagnose, treat, or otherwise affect an individual's physical or mental condition, and includes medical care as defined in T.C.A. § 32-11-103(5).

(33~~1~~) Health Care Decision. Consent, refusal of consent or withdrawal of consent to health care.

(34~~2~~) Health Care Decision-maker. In the case of a patient who lacks capacity, the patient's health care decision-maker is one of the following: the patient's health care agent as specified in an advance directive, the patient's court-appointed guardian or conservator with health care decision-making authority, the patient's surrogate as determined pursuant to Rule 1200-08-10-.13 or T.C.A. § 33-3-220, the designated physician pursuant to these Rules or in the case of a minor child, the person having custody or legal guardianship.

(35~~3~~) Health Care Institution. A health care institution as defined in T.C.A. § 68-11-1602.

(36~~4~~) Health Care Provider. A person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care in the ordinary course of business or practice of a profession.

(37~~5~~) Hospital. Any institution, place, building or agency represented and held out to the general public as ready, willing and able to furnish care, accommodations, facilities and equipment for the use, in connection with services of a physician or dentist, to one (1) or more non-related persons who may be suffering from deformity, injury or disease or from any other condition for which nursing, medical or surgical services would be appropriate for care, diagnosis or treatment.

(38~~6~~) Incompetent. A patient who has been adjudicated incompetent by a court of competent jurisdiction and has not been restored to legal capacity.

(39~~7~~) Individual instruction. An individual's direction concerning a health care decision for the individual.

(40~~38~~) Infectious Waste. Solid or liquid wastes which contain pathogens with sufficient virulence and quantity such that exposure to the waste by a susceptible host could result in an infectious disease.

(41~~39~~) Licensed Practical Nurse. A person currently licensed as such by the Tennessee Board of Nursing.

(42~~0~~) Licensee. The person or entity to whom the license is issued. The licensee is held responsible for compliance with all applicable rules and regulations.

(43~~1~~) Life Threatening or Serious Injury. Injury requiring the patient to undergo significant additional diagnostic or treatment measures.

(44~~2~~) Medical emergency. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

(Rule 1200-08-10-.01, continued)

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

(464) Medical Staff. An organized body composed of individuals appointed by the ambulatory surgical treatment center governing board. All members of the medical staff shall be licensed to practice in Tennessee, with the exception of interns and residents.

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

(486) Mid-Level Practitioner. A registered nurse licensed in Tennessee who holds a master's degree in a clinical nursing specialty, national certification through the ANCC or American Academy of Nurse Practitioners and holds a certificate of fitness to prescribe from the Tennessee Board of Nursing.

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

(5048) Neglect. The failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness; however, the withholding of authorization for or provision of medical care to any terminally ill person who has executed an irrevocable living will in accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of the living will, shall not be deemed "neglect" for purposes of these rules.

(5149) N.F.P.A. National Fire Protection Association.

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

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

(542) PALS. Pediatric Advance Life Support.

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

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

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

(Rule 1200-08-10-.01, continued)

(5~~8~~6) Physician Assistant. A person who has graduated from a physician assistant educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant, has passed the Physician Assistant National Certifying Examination, and is currently licensed in Tennessee as a physician assistant under title 63, chapter 19.

(5~~9~~7) Physician Orders for Scope of Treatment or POST. Written orders that:

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

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

(c)

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

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

3. Specify both 1 and 2.

(60~~58~~) Podiatrist. A person currently licensed as such by the Tennessee Board of Registration in Podiatry.

(61~~59~~) Power of Attorney for Health Care. The designation of an agent to make health care decisions for the individual granting the power under T.C.A. Title 34, Chapter 6, Part 2.

(6~~2~~0) Qualified Emergency Medical Service Personnel. Includes, but shall not be limited to, emergency medical technicians, paramedics, or other emergency services personnel, providers, or entities acting within the usual course of their professions, and other emergency responders.

(6~~3~~1) Radiological Technologist. A person currently certified as such by the American Society of Radiological Technologists.

(6~~4~~2) Reasonably Available. Readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient's health care needs. Such availability shall include, but not be limited to, availability by telephone.

(6~~5~~3) Registered Nurse (R.N.). A person currently licensed as such by the Tennessee Board of Nursing.

(6~~6~~4) Registered Record Administrator (RRA). A person currently registered as such by the American Medical Records Association.

(6~~7~~5) Shall or Must. Compliance is mandatory.

(6~~8~~6) State. A state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.

(69~~67~~) Supervising Health Care Provider. The designated physician or, if there is no designated physician or the designated physician is not reasonably available, the health care provider who has undertaken primary responsibility for an individual's health care.

(Rule 1200-08-10-.01, continued)

(70~~68~~) Surgical Procedure. A manual or operative method performed by a licensed medical practitioner to treat diseases, injuries, conditions and/or deformities. (As related to pregnancy termination, surgical procedure excludes, but is not limited to, PAP smear or vaginal examinations, ultrasounds, amniocentesis, intramuscular injections.)

(71~~69~~) Surgical Technologist. A person who works under supervision to facilitate the safe and effective conduct of invasive surgical procedures. This individual is usually employed by a hospital, medical office, or surgical center and supervised during the surgical procedure according to institutional policy and procedure to assist in providing a safe operating room environment that maximizes patient safety by performing certain tasks including, but not limited to:

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

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

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

(72~~0~~) Surrogate. An individual, other than a patient's agent or guardian, authorized to make a health care decision for the patient.

(73~~1~~) Transfer. The movement of a patient at the direction of a physician or other qualified medical personnel when a physician is not readily available but does not include such movement of a patient who leaves the facility against medical advice.

(74~~2~~) Treating Health Care Provider. A health care provider who at the time is directly or indirectly involved in providing health care to the patient.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 39-11-106, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-211, 68-11-216, 68-11-224, 68-11-1802, 68-57-101, 68-57-102, and 68-57-105.* ***Administrative History:*** *Original rule filed July 22, 1977; effective August 22, 1977. Amendment filed August 10, 1982; effective September 9, 1982. Repeal and new rule filed June 30, 1992; effective August 14, 1992. Amendment filed March 12, 1993; effective April 26, 1993. Repeal and new rule filed March 21, 2000; effective June 4, 2000. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed April 28, 2003; effective July 12, 2003. Amendment filed June 16, 2003; effective August 30, 2003. Amendment filed May 20, 2004; effective August 3, 2004. Amendments filed September 9, 2005; effective November 23, 2005. Amendment filed February 23, 2006; effective May 9, 2006. Amendment filed February 7, 2007; effective April 23, 2007. Amendment filed February 22, 2010; effective May 23, 2010. Amendment filed January 3, 2012; effective April 2, 2012. Amendment filed March 27, 2015; effective June 25, 2015.*

1200-08-10-.02 LICENSING PROCEDURES.

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

(Rule 1200-08-10-.02, continued)

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

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

(b) Each applicant for a license shall pay an annual license fee in the amount of one thousand four hundred and four dollars ($1,404.00). The fee must be submitted with the application and is not refundable.

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

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

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

(f) The applicant shall allow the ambulatory surgical treatment center to be inspected by a Department surveyor. In the event that deficiencies are noted, the applicant shall submit a plan of corrective action to the Board that must be accepted by the Board. Once the deficiencies have been corrected, then the Board shall consider the application for licensure.

(3) Each ASTC, when issued a license, shall be classified according to the type of services rendered or category of patients served. The ASTC shall confine its services to those described in its license and shall advertise only the services which it is licensed to perform. The classification shall be listed on the license.

(4) A proposed change of ownership must be reported to the department a minimum of thirty (30) days prior to the change. A new application and fee must be received by the department before the license may be issued.

(a) For purposes of licensing, the licensee of an ASTC has the ultimate responsibility for the operation of the facility, including the final authority to make or control operational decisions and legal responsibility for the business management. A change of ownership occurs whenever this ultimate legal authority for the responsibility of ASTC operations is transferred.

(b) A change of ownership occurs whenever there is a change in the legal structure by which the facility is owned and operated and any ownership interest of the preceding or succeeding entity changes.

(c) Transactions constituting a change of ownership include, but are not limited to, the following:

1. Transfer of the facility’s legal title;

2. Lease of the facility’s operation;

(Rule 1200-08-10-.02, continued)

3. Dissolution of any partnership that owns, or owns a controlling interest in, the facility;

4. One partnership is replaced by another through the removal, addition or substitution of a partner;

5. Merger of a facility owner (a corporation) into another corporation where, after the merger, the owner's shares of capital stock are canceled;

6. The consolidation of a corporate facility owner with one or more corporations; or,

7. 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. Two (2) or more corporations merge and the originally-licensed corporation survives;

3. Changes in the membership of a non-profit corporation;

4. Transfers between departments of the same level of government; or,

5. Corporate stock transfers or sales, even when a controlling interest.

(e) Management agreements are generally not changes of ownership if the owner continues to retain ultimate authority for the operation of the facility. However, if the ultimate authority is surrendered and transferred from the owner to a new manager, then a change of ownership has occurred.

(f) Sale/lease-back agreements shall not be treated as changes in ownership if the lease involves the facility's entire real and personal property and if the identity of the leasee, who shall continue the operation, retains the same legal form as the former owner.

(5) Renewal.

(a) In order to renew a license, each ambulatory surgical treatment center shall submit to periodic inspections by Department surveyors for compliance with these rules. If deficiencies are noted, the licensee shall submit an acceptable plan of corrective action and shall remedy the deficiencies. In addition, each licensee shall submit a renewal form approved by the board and applicable renewal fee prior to the expiration date of the license.

(b) If a licensee fails to renew its license prior to the date of its expiration but submits the renewal form and fee within sixty (60) days thereafter, the licensee may renew late by paying, in addition to the renewal fee, a late penalty of one hundred dollars ($100) per month for each month or fraction of a month that renewal is late; provided that the late penalty shall not exceed twice the renewal fee.

(Rule 1200-08-10-.02, continued)

(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;

2. The license fee provided in rule 1200-08-10-.02(2)(b); and

3. Any other information required by the Health Services and Development Agency.

(d) Upon reapplication, the licensee shall submit to an inspection of the facility by Department of Health surveyors.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206(a)(5), 68-11-206, 68-11-209, 68-11-209(a)(1), 68-11-210, 68-11-216, and Chapter 846 of the Public Acts of 2008, §1.* ***Administrative History:*** *Original rule filed July 22, 1977; effective August 22, 1977. Amendment filed February 26, 1985; effective March 28, 1985. Repeal and new rule filed June 30, 1992; effective August 14, 1992. Repeal and new rule filed March 21, 2000; effective June 4, 2000. Amendment filed June 16, 2003; effective August 30, 2003. Amendment filed January 19, 2007; effective April 4, 2007. Amendment filed July 18, 2007; effective October 1, 2007. Public necessity rules filed April 29, 2009; effective through October 11, 2009. Emergency rules filed October 9, 2009; effective through April 7, 2010. Amendments filed September 24, 2009; effective December 23, 2009. Amendment filed December 16, 2013; effective March 16, 2014. Amendments filed March 21, 2018; to have been effective June 19, 2018. However, on May 24, 2018, the Government Operations Committee filed a 5-day stay; new effective date June 24, 2018.*

1200-08-10-.03 DISCIPLINARY PROCEDURES.

(1) The board may suspend or revoke a license for:

(a) Violation of federal or state statutes;

(b) Violation of the rules as set forth in this chapter;

(c) Permitting, aiding or abetting the commission of any illegal act in the ASTC;

(d) Conduct or practice found by the board to be detrimental to the health, safety, or welfare of the patients of the ASTC; and

(e) Failure to renew license.

(2) The board may consider all factors which it deems relevant, including but not limited to the following when determining sanctions:

(a) The degree of sanctions necessary to ensure immediate and continued compliance;

(b) The character and degree of impact of the violation on the health, safety and welfare of the patients in the facility;

(c) The conduct of the facility in taking all feasible steps or procedures necessary or appropriate to comply or correct the violation; and,

(d) Any prior violations by the facility of statutes, regulations or orders of the board.

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

(3) When an ambulatory surgical treatment center is found by the department to have committed a violation of this chapter, the department will issue to the facility a statement of deficiencies. Within ten (10) days of the receipt of the statement of deficiencies the facility must return a policy of correction indicating 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.

(4) Either failure to submit a plan of correction in a timely manner or a finding by the department that the plan of correction is unacceptable shall subject the ambulatory surgical treatment center's license to possible disciplinary action.

(5) Any licensee or applicant for a license, aggrieved by a decision or action of the department or board, pursuant to this chapter, may request a hearing before the board. The proceedings and judicial review of the board's decision shall be in accordance with the Uniform Procedures Act, T.C.A. §§ 4-5-101 et seq.

(6) Reconsideration and Stays. The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-04-01-.18 regarding petitions for reconsiderations and stays in that case.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 4-5-219, 4-5-312, 4-5-316, 4-5-317, 68-11-202, 68-11-204, 68-11-206, 68-11-208, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed July 22, 1977; effective August 22, 1977. Repeal and new rule filed June 30, 1992; effective August 14, 1992. Repeal and new rule filed March 21, 2000; effective June 4, 2000. Amendment filed March 1, 2007; effective May 15, 2007.*

1200-08-10-.04 ADMINISTRATION.

(1) The ASTC must have an effective governing body legally responsible for the conduct of the ASTC. If an ASTC does not have an organized governing body, the persons legally responsible for the conduct of the ASTC must carry out the functions specified in this chapter.

(2) The governing body shall appoint a chief executive officer or administrator who is responsible for managing the ASTC. The chief executive officer or administrator shall designate an individual to act for him or her in his or her absence, in order to provide the ASTC with administrative direction at all times.

(3) The governing body, whether it be that of the center alone or that of a parent organization, shall establish effective mechanisms to ensure the accountability of the center's medical staff and other professional personnel.

(4) The governing body shall assure that the ASTC has the financial resources to provide the services essential to the operation of the facility.

(5) Staffing shall be adequate to provide the services essential to the operation of the ASTC.

(Rule 1200-08-10-.04, continued)

(6) The ambulatory surgical treatment center shall ensure a framework for addressing issues related to care at the end of life.

(7) The ambulatory surgical treatment center shall provide a process that assesses pain in all patients. There shall be an appropriate and effective pain management program.

(8) The ASTC shall perform only those surgical procedures which can be safely and effectively carried out on an outpatient basis.

(9) Each ASTC shall have at all times a designated Medical Director who shall be a licensed physician or dentist who shall be responsible for the direction and coordination of medical programs.

(10) Staff education programs and training sessions shall include life safety, medical equipment, utility systems, infection control and hazardous waste practices. At least two (2) on duty members of the facility shall be trained in emergency resuscitation.

(11) When licensure is applicable for a particular job, a copy of the current license must be included as a part of the personnel file. Each personnel file shall contain accurate information as to the education, training, experience and personnel background of the employee. Adequate medical screenings to exclude communicable disease shall be required of each employee.

(12) Whenever the rules and regulations of this chapter require that a licensee develop a written policy, plan, procedure, technique, or system concerning a subject, the licensee shall develop the required policy, maintain it and adhere to its provisions. An ASTC which violates a required policy also violates the rule and regulation establishing the requirement.

(13) Policies and procedures shall be consistent with professionally recognized standards of practice.

(14) No ASTC shall retaliate against or, in any manner, discriminate against any person because of a complaint made in good faith and without malice to the board, the department, the Adult Protective Services, or the Comptroller of the State Treasury. An ASTC shall neither retaliate, nor discriminate, because of information lawfully provided to these authorities, because of a person's cooperation with them, or because a person is subpoenaed to testify at a hearing involving one of these authorities.

(15) When services such as dietary, laundry or therapy services are purchased from others, the governing body shall be responsible to assure the supplier(s) meet the same local and state standards the facility would have to meet if it were providing those services itself using its own staff.

(16) The governing body shall provide for the appointment, reappointment or dismissal of members of the medical, dental, and other health professions and provide for the granting of clinical privileges.

(17) The governing body shall ensure that there is a written facility agreement with one or more acute care general hospitals licensed by the state, which will admit any patient referral who requires continuing care.

(18) Each ASTC shall specify the classification of services to be provided in the facility and list authorized surgical procedures.

(Rule 1200-08-10-.04, continued)

(19) Where the physician-owner-operator serves as the governing body, the articles of incorporation or other written organizational plan shall describe the manner in which the owner-operator executes the governing body responsibility.

(20) Infection Control.

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

(b) The physical environment of the ambulatory surgical treatment center shall be maintained in a safe, clean and sanitary manner.

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

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

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

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

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

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

1. Written infection control policies;

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

(Rule 1200-08-10-.04, continued)

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

   (i) Hand hygiene (as defined in 1200-08-10-.04(20)(g));

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

   (iii) Chlorhexidine skin antisepsis;

   (iv) Optimal site selection;

   (v) Daily review of line necessity; and

   (vi) Development and utilization of a procedure checklist;

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

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

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

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

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

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

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

(f) The facility shall have an annual influenza vaccination program which shall include at least:

1. The offer of influenza vaccination to all staff and independent practitioners or accept documented evidence of vaccination from another vaccine source or facility;

(Rule 1200-08-10-.04, continued)

2. A signed declination statement on record from all who refuse the influenza vaccination for other than medical contraindications;

3. Education of all direct care personnel about the following:

(i) Flu vaccination,

(ii) Non-vaccine control measures, and

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

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

5. The requirements to complete vaccinations or declination statements are suspended by the Medical Director in the event of a vaccine shortage.

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

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

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

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

4. Health care worker education programs which may include:

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

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

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

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

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

(i) Unless otherwise permitted pursuant to this section, no person shall practice as a central service technician unless the person:

1. Has successfully passed a nationally accredited central service exam for central service technicians and holds and maintains one (1) of the following credentials:

(i) A certified registered central service technician credential administered by the International Association of Healthcare Central Service Material

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Management; or

(ii) A certified sterile processing and distribution technician credential administered by the Certification Board for Sterile Processing and Distribution, Inc.; or

2. Was employed or otherwise contracted for services as a central service technician in a healthcare institution before January 1, 2017; or

3. Obtains a certified registered central service technician credential administered by the International Association of Healthcare Central Service Material Management or the Certification Board for Sterile Processing and Distribution, Inc., not later than two (2) years after the person's date of hire or contracting for services with a healthcare institution.

4. A central service technician shall complete a minimum of ten (10) hours of continuing education within a calendar year. The continuing education shall be in areas related to the functions of a central service technician. Continuing education shall be maintained in the employee's personnel file. National certification shall satisfy this requirement.

5. Nothing in this section shall prohibit the following persons from performing the tasks or functions of a central service technician:

(i) A healthcare provider operating within the scope of practice for that provider established pursuant to title 63;

(ii) A surgical technologist operating within the scope of practice established by § 68-57-105;

(iii) A student or intern performing the functions of a central service technician under the direct supervision of a healthcare provider as part of the student's or intern's training or internship; or

(iv) A person who does not work in a central service department in a healthcare facility, but who has been specially trained and determined competent, based on standards set by a healthcare institution's infection prevention or control committee, acting in consultation with a central service technician certified in accordance with subsection (b), to decontaminate or sterilize reusable medical equipment, instruments, or devices, in a manner that meets applicable manufacturer's instructions and standards.

6. A healthcare institution shall retain a list of persons determined to be competent under subsection (d). The list shall include job titles for such persons. A person determined to be competent pursuant to subsection (d) shall annually complete a minimum of ten (10) hours of continuing education in areas related to infection control and the decontamination and sterilization of reusable medical equipment, instruments and devices.

7. Any healthcare institution that employs or contracts with a central service technician shall submit to the department of health, upon request, including, but not limited to, during an inspection performed pursuant to this part, documentation demonstrating that the central service technician complies with the requirements of this section.

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(Rule 1200-08-10-.04, continued)

(21) Performance Improvement. The ASTC shall have a planned, systematic, organization-wide approach to process design and redesign, performance measurement, assessment and improvement which is approved by the designated medical staff committee of the facility, the owner and/or the governing body. This plan shall address and/or include, but is not limited to:

(a) Infection control, including post-operative surveillance;

(b) Complications arising after the patient was admitted;

(c) Documentation of periodic review of the data collected and follow-up actions;

(d) A system which identifies appropriate plans of action to correct identified quality deficiencies;

(e) Documentation that the above policies are being followed and that appropriate action is taken whenever indicated.

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

(22) The ASTC shall ensure a framework for addressing issues related to care at the end of life.

(23) The ASTC shall provide a process that assesses pain in all patients. There shall be an appropriate and effective pain management program.

(24) All health care facilities licensed pursuant to T.C.A. §§ 68-11-201, et seq. shall post the following in the main public entrance:

(a) Contact information including statewide toll-free number of the division of adult protective services, and the number for the local district attorney's office;

(b) A statement that a person of advanced age who may be the victim of abuse, neglect, or exploitation may seek assistance or file a complaint with the division concerning abuse, neglect and exploitation; and

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

Postings of (a) and (b) shall be on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height.

(25) "No smoking" signs or the international "No Smoking" symbol, consisting of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it, shall be clearly and conspicuously posted at every entrance.

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

(27) Informed Consent

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(Rule 1200-08-10-.04, continued)

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

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

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

(c) A facility in which abortions are performed that is an ambulatory surgical treatment center shall post the required sign in each patient waiting room and patient consultation room used by patients on whom abortions are performed.

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

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

2. An abortion other than an abortion necessary to prevent the death of the pregnant female was performed in the ambulatory surgical treatment center.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 39-15-202, 39-17-1803, 39-17-1805, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-216, 68-11-268, and 71-6-121.* ***Administrative History:*** *Original rule filed July 22, 1977; effective August 22, 1977. Amendment filed September 10, 1991; effective October 25, 1991. Repeal and new rule filed June 30, 1992; effective August 14, 1992. Repeal and new rule filed March 21, 2000; effective June 4, 2000. Amendment filed June 18, 2002; effective September 1, 2002. Amendment filed June 16, 2003; effective August 30, 2003. Amendment filed September 9, 2005; effective November 23, 2005. Amendment filed April 20, 2006; effective July 4, 2006. Amendment filed July 18, 2007; effective October 1, 2007. Amendment filed October 11, 2007; effective December 25, 2007. Amendment filed February 22, 2010; effective May 23, 2010. Amendment filed December 16, 2013; effective March 16, 2014. Amendments filed July 10, 2018; effective October 8, 2018.*

1200-08-10-.05 ADMISSIONS, DISCHARGES, AND TRANSFERS.

(1) Every person admitted for care or treatment to any ASTC shall be under the supervision of a physician licensed to practice in Tennessee. The name, address and telephone number of the physician attending the patient shall be recorded in the patient's medical record.

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

(3) This does not preclude qualified oral and maxillo-facial surgeons from admitting patients and completing the admission history and physical examination and assessing the medical risk of

(Rule 1200-08-10-.05, continued)

the procedure on their patients. A physician member of the medical staff is responsible for the management of medical problems.

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

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

(6) Each ASTC must have a written transfer agreement with a local hospital.

(7) The ASTC shall develop a patient referral system both for referrals within the facility and other health care providers.

(8) The ASTC shall have available a plan for emergency transportation to a licensed local hospital.

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

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

(b) Begin upon admission;

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

(d) Include the likelihood of a patient's capacity for self-care or the possibility of the patient returning to his or her pre-ambulatory surgical treatment center environment.

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

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

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

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed July 22, 1977; effective August 22, 1977. Repeal and new rule filed June 30, 1992; effective August 14, 1992. Repeal and new rule filed March 21, 2000; effective June 4, 2000. Amendment filed June 16, 2003; effective August 30, 2003.*

1200-08-10-.06 BASIC SERVICES.

(Rule 1200-08-10-.06, continued)

(1) Surgical Services.

(a) Facilities restricted in services they provide, e.g. those that restrict services to radiation therapy or use of local anesthetics only, may be exempted from all or part of the requirements of this rule pertaining to laboratory services, food and dietetic services, surgical services, and anesthesia services.

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

(c) A hospital may choose to separately license a portion of the facility as an Ambulatory Surgical Treatment Center; the licensure fee for such is not required.

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

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

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

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

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

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

(j) Surgical technologists must:

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

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

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

(Rule 1200-08-10-.06, continued)

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

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

(k) An ASTC can petition the director of health care facilities of the department for a waiver from the provisions of 1200-08-10-.06(1)(j) if they are unable to employ a sufficient number of surgical technologists who meet the requirements. The facility shall demonstrate to the director that a diligent and thorough effort has been made to employ surgical technologist who meet the requirements. The director shall refuse to grant a waiver upon finding that a diligent and thorough effort has not been made. A waiver shall exempt a facility from meeting the requirements for not more than nine (9) months. Additional waivers may be granted, but all exemptions greater than twelve (12) months shall be approved by the Board for Licensing Health Care Facilities.

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

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

(n) Properly executed informed consent, advance directive, if available, and organ donation forms, if available, must be in the patient's chart before surgery, except in emergencies. The patient is not required to sign advance directive and organ donation forms.

(o) Adequate equipment and supplies must be available as determined by the governing body and the medical staff, and must meet the current acceptable standards of practice in the ASTC industry. In conjunction with their governing body and the medical staff, the facility shall develop policies and procedures specifying the types of emergency equipment that are appropriate for the facility's patient population, and shall make the items immediately available at the ASTC to handle inter- or post-operative emergencies.

(p) At least one registered nurse shall be in the recovery area during the patient's recovery period.

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

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

(Rule 1200-08-10-.06, continued)

(s) The ASTC shall provide one or more surgical suites which shall be constructed, equipped, and maintained to assure the safety of patients and personnel.

(t) Surgical suites are required to meet the same standards as hospital operating rooms, including those using general anesthesia.

(u) The ASTC shall have separate areas for waiting rooms, recovery rooms, treatment and/or examining rooms.

(2) Anesthesiology Services. Anesthesia shall be administered by:

(a) A qualified anesthesiologist;

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

(c) A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;

(d) A certified registered nurse anesthetist (CRNA); or

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

(f) After the completion of anesthesia, patients shall be constantly attended by competent personnel until responsive and able to summon aid. Each center shall maintain a log of the inspections made prior to each day's use of the anesthesia equipment. A record of all service and maintenance performed on all anesthesia machines, vaporizers and ventilators shall also be on file.

(g) When inhaled general anesthesia known to trigger malignant hyperthermia and/or succinylcholine are maintained in the facility, there shall be thirty-six (36) ampules of Dantrolene for injection onsite. This requirement applies to anesthesia agents, current or future, that are shown to cause malignant hyperthermia. If Dantrolene is administered, appropriate monitoring must be provided post-operatively.

(h) Written policies and procedures relative to the administration of anesthesia shall be developed and approved by the Medical Staff and governing body.

(i) Any patient receiving conscious sedation shall receive:

1. Continuous EKG monitoring;

2. Continuous oxygen saturations;

3. Serial BP monitoring at intervals no less than every 5 minutes; and

4. Supplemental oxygen therapy and immediately available:

(i) Ambubag;

(ii) Suction;

(iii) Endotracheal tube; and

(iv) Crash cart.

(Rule 1200-08-10-.06, continued)

(3) Medical Staff.

(a) The ASTC shall have a medical staff organized under written by-laws that are approved by the governing body. The medical staff of the ASTC shall define a mechanism to:

1. Assure that an optimal level of professional performance is maintained;

2. Appoint independent practitioners through a defined credentialing process;

3. Apply credentialing criteria uniformly;

4. Utilize the current license, relevant training and experience, current competence and the ability to perform requested privileges in the credentialing process; and

5. Provide for participation in required committees of the facility to ensure that quality medical care is provided to the patients.

(b) Each licensed independent practitioner shall provide care under the auspices of the facility in accordance with approved privileges.

(c) Clinical privileges shall be granted based on the practitioners' qualifications and the services provided by the facility, and shall be reviewed and/or revised at least every two (2) years.

(4) Nursing Service. A licensed registered nurse (R.N.) shall be on duty at all times. Additional appropriately trained staff shall be provided as needed to ensure that the medical needs of the patients are fully met.

(a) The ASTC shall be organized under written policies and procedures relating to patient care, establishment of standards for nursing care and mechanisms for evaluating such care and nursing services.

(b) A qualified registered nurse designated by the administrator shall be responsible for coordinating and supervising all nursing services.

(c) There shall be a sufficient staffing pattern of registered nurses to provide quality nursing care to each surgical patient from admission through discharge. Additional staff shall be on duty and available to assist the professional staff to adequately handle routine and emergency patient needs.

(d) The ASTC shall establish written procedures for emergency services which will ensure that professional staff members who have been trained in emergency resuscitation procedures shall be on duty at all times when there is a patient in the ASTC and until the patient has been discharged.

(e) Nursing care policies and procedures shall be consistent with professionally recognized standards of nursing practice and shall be in accordance with the Nurse Practice Act of the State of Tennessee and the Association of Operating Room Nurses Standards of Practice.

(f) Staff development and training shall be provided to the nursing staff and other ancillary staff in order to maintain and improve knowledge and skills. The educational/training program shall be planned, documented and conducted on a continuing basis. There

(Rule 1200-08-10-.06, continued)

shall be at least appropriate training on equipment, safety concerns, infection control and emergency care on an annual basis.

(5) Pharmaceutical Services. The ASTC must provide drugs and biologicals in a safe and effective manner in accordance with accepted standards of practice. Such drugs and biologicals must be stored in a separate room or cabinet which shall be kept locked at all times.

(6) Ancillary Services. All ancillary or supportive health or medical services, including but not limited to, radiological, pharmaceutical, or medical laboratory services shall be provided in accordance with all applicable state and federal laws and regulations.

(7) Radiological Services. The ASTC shall provide within the facility, or through arrangement, diagnostic radiological services commensurate with the needs of the ambulatory surgical treatment center.

(a) If radiological services are provided by facility staff, the services shall be maintained free of hazards for patients and personnel.

(b) New installations of radiological equipment, and subsequent inspections for the identification of radiation hazards shall be made as specified in state and federal requirements.

(c) Personnel monitoring shall be maintained for each individual working in the area of radiation. Readings shall be on at least a monthly basis and reports kept on file and available for review.

1. Personnel - The ASTC shall have a radiologist either full-time or part-time on a consulting basis, both to supervise the service and to discharge professional radiological services.

2. The use of all radiological apparatus shall be limited to personnel designated as qualified by the radiologist; and use of fluoroscopes shall be limited to physicians.

(d) If provided under arrangement with an outside provider, the radiological services must be directed by a qualified radiologist and meet state and federal requirements.

(8) Laboratory Services.

(a) The ASTC shall provide on the premises or by written agreement with a laboratory licensed under T.C.A. § 68-29-105, a clinical laboratory to provide those services commensurate with the needs and services of the ASTC.

(b) Any patient terminating pregnancy in an ASTC shall have an Rh type, documented prior to the procedure, performed on her blood. In addition, she shall be given the opportunity to receive Rh immune globulin after an appropriate crossmatch procedure is performed within a licensed laboratory.

(9) Food and Dietetic Services. If a patient will be in the facility for more than four (4) hours post-op, an appropriate diet shall be provided.

(10) Environmental Services.

(Rule 1200-08-10-.06, continued)

(a) The facility shall provide a safe, accessible, effective and efficient environment of care consistent with its mission, service, law and regulation.

(b) The facility shall develop policies and procedures that address:

1. Safety;

2. Security;

3. Control of hazardous materials and waste;

4. Emergency preparedness;

5. Life safety;

6. Medical equipment; and,

7. Utility systems.

(c) Staff shall have been oriented to and educated about the environment of care and possess knowledge and skills to perform responsibilities under the environment of care policies and procedures.

(d) Utility systems, medical equipment, life safety elements, and safety elements of the environment of care shall be maintained, tested and inspected.

(e) Safety issues shall be addressed and resolved.

(f) Appropriate staff shall participate in implementing safety recommendations and monitoring their effectiveness.

(g) The building and grounds shall be suitable to services provided and patients served.

(11) Infection Control. An Ambulatory Surgical Treatment Center shall have an annual influenza vaccination program which shall include at least:

(a) The offer of influenza vaccination to all staff and independent practitioners at no cost to the person or acceptance of documented evidence of vaccination from another vaccine source or facility. The Ambulatory Surgical Treatment Center will encourage all staff and independent practitioners to obtain an influenza vaccination;

(b) A signed declination statement on record from all who refuse the influenza vaccination for reasons other than medical contraindications (a sample form is available at https://www.tn.gov/content/dam/tn/health/documents/SampleIndividualFluForm.pdf);

(c) Education of all employees about the following:

1. Flu vaccination,

2. Non-vaccine control measures, and

3. The diagnosis, transmission, and potential impact of influenza;

(d) An annual evaluation of the influenza vaccination program and reasons for non-participation; and

(Rule 1200-08-10-.06, continued)

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

(12) Medical Records.

(a) The ASTC shall comply with the Medical Records Act of 1974, T.C.A. §§ 68-11-301, et seq.

(b) A medical record shall be maintained for each person receiving medical care provided by the ASTC and shall include:

1. Patient identification;

2. Name of nearest relative or other responsible agent;

3. Identification of primary source of medical care;

4. Dates and times of visits;

5. Signed informed consent;

6. Pertinent medical history;

7. Diagnosis;

8. Physician examination report;

9. Anesthesia records of pertinent preoperative and postoperative reports including preanesthesia evaluation, type of anesthesia, technique and dosage used;

10. Operative report;

11. Discharge summary, including instructions for self care and instructions for obtaining postoperative emergency care;

12. Reports of all laboratory and diagnostic procedures along with tests performed and the results authenticated by the appropriate personnel; and,

13. X-ray reports.

(c) Medical records shall be current and confidential. Medical records and copies thereof shall be made available when requested by an authorized representative of the board or the department.

(13) Invasive Procedures

(a) For purposes of interventional pain management, only a medical doctor, licensed pursuant to T.C.A. §§ 63-6-101 et seq., or an osteopathic physician, licensed pursuant to T.C.A. §§ 63-9-101 et seq., who meets the following qualifications will be permitted to perform invasive procedures of the spine, spinal cord, sympathetic nerves of the spine or block of major peripheral nerves of the spine.

(Rule 1200-08-10-.06, continued)

1. Board certified through the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) or the American Board of Physician Specialties (ABPS)/American Association of Physician Specialists (AAPS) in one of the following medical specialties:

   (i) Anesthesiology;

   (ii) Neurological surgery, or Neuromusculoskeletal medicine;

   (iii) Orthopedic surgery;

   (iv) Physical medicine and rehabilitation;

   (v) Radiology; or

   (vi) Any other board certified physician who had completed an ABMS subspecialty board in pain medicine or completed an ACGME accredited pain fellowship;

2. A recent graduate in a medical specialty listed in part 1 not yet eligible to apply for ABMS, AOA, or ABPS/AAPS board certification; provided, there is a practice relationship with a medical doctor or an osteopathic physician who meets the requirements of part 1.;

3. A licensee who is not board certified in one of the specialties listed in part 1, but is board certified in a different ABMS, AOA, or ABPS/AAPS specialty and has completed a post-graduate training program in interventional pain management approved by the board;

4. A licensee who serves as a clinical instructor in pain medicine at an accredited Tennessee medical training program; or

5. A licensee who has an active pain management practice in a clinic accredited in outpatient interdisciplinary pain rehabilitation by the Commission on Accreditation of Rehabilitation Facilities or any successor organizations.

6. This subparagraph (13)(a) shall not apply to a medical doctor, licensed pursuant to T.C.A. §§ 63-6-101 et seq., or an osteopathic physician, licensed pursuant to T.C.A. §§ 63-9-101 et seq., in the placement of medical devices used in the treatment of conditions not primarily related to pain.

(b) An advanced practice nurse or physician assistant shall only perform invasive procedures involving any portion of the spine, spinal cord, sympathetic nerves of the spine or block of major peripheral nerves of the spine under the direct supervision of a medical doctor or an osteopathic physician who meets the qualifications of Rule 1200-08-10-.06 (12)(a)1. or 3. Direct supervision is defined as being physically present in the center at the time the invasive procedure is performed.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68, 68-11-209, 68-11-216, 68-57-101, 68-57-102, 68-57-104, and 68-57-105.* ***Administrative History:*** *Original rule filed July 22, 1977; effective August 22, 1977. Amendment filed September 10, 1991; effective October 25, 1991. Repeal and new rule filed June 30, 1992; effective August 14, 1992. Repeal and new rule filed March 21, 2000; effective June 4, 2000. Amendment filed June 16, 2003; effective August 30, 2003. Amendment filed February 23, 2006; effective May 9, 2006. Amendment filed February 23, 2007; effective May 9, 2007. Amendment filed February 22, 2010; effective May 23, 2010. Amendment filed*

(Rule 1200-08-10-.06, continued)
January 3, 2012; effective April 2, 2012. Amendment filed December 16, 2013; effective March 16, 2014. Amendments filed March 27, 2015; effective June 25, 2015. Amendment filed October 20, 2015; effective January 18, 2016. Amendments filed July 18, 2016; effective October 16, 2016. Amendments filed January 7, 2019; to have become effective April 7, 2019. However, the Government Operations Committee filed a 60-day stay of the effective date of the rules; new effective date June 6, 2019.

1200-08-10-.07 RESERVED.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-209, and 68-57-105.* ***Administrative History:*** *Original rule filed June 30, 1992; effective August 14, 1992. Repeal and new rule filed March 4, 2000; effective June 4, 2000. Amendment filed June 16, 2003; effective August 30, 2003. Amendment filed January 3, 2012; effective April 2, 2012.*

1200-08-10-.08 BUILDING STANDARDS.

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

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

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

(4) The licensed contractor shall perform all new construction and renovations to ASTCs, 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 ASTCs, including the submission of phased construction plans and the final drawings and the specifications to each.

(5) No new ASTC shall be constructed, nor shall major alterations be made to an existing ASTC without prior written approval of the department, and unless in accordance with plans and specifications approved in advance by the department. Before any new ASTC is licensed or before any alteration or expansion of a licensed ASTC 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.

(Rule 1200-08-10-.08, continued)

(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 where applicable:

(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 where applicable:

(Rule 1200-08-10-.08, continued)

(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 where applicable:

(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 where applicable:

(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) An electrical system that complies with applicable codes;

(d) Color coding to show all items on emergency power;

(e) Circuit breakers that are properly labeled; and

(f) Ground-Fault Circuit Interrupters (GFCI) that are required in all wet areas, such as kitchens, laundries, janitor closets, bath and toilet rooms, etc, and within six (6) feet of any lavatory.

(14) The electrical drawings shall not include knob and tube wiring, shall not include electrical cords that have splices, and shall not show that the electrical system is overloaded.

(15) In all new facilities or renovations to existing electrical systems, the installation must be approved by an inspector or agency authorized by the State Fire Marshal.

(16) Sprinkler drawings shall include where applicable:

(a) Shop drawings, hydraulic calculations, and manufacturer cut sheets;

(Rule 1200-08-10-.08, continued)

(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.

(17) 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 ASTC 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.

(18) It shall be demonstrated through the submission of plans and specifications that in each ASTC 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.

(19) The department shall acknowledge that it has reviewed plans and specifications in writing with copies sent to the project architect, the project engineer, the owner, the manager or other executive of the institution. The department may modify the distribution of such review at its discretion.

(20) In the event submitted materials do not appear to satisfactorily comply with 1200-08-10-.08(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.

(21) The licensed contractor shall execute all construction in accordance with the approved plans and specifications.

(22) 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 1200-08-10-.08(2). 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.

(23) Prior to final inspection, a CD Rom disc, in TIF or PDF format, of the final approved plans including all shop drawings, sprinkler, calculations, hood and duct, addenda, specifications, etc., shall be submitted to the department.

(24) The department requires the following alarms that shall be monitored twenty-four (24) hours per day:

(Rule 1200-08-10-.08, continued)

(a) Fire alarms;

(b) Generators (if applicable); and

(c) Medical gas alarms (if applicable).

(25) With the submission of plans the facility shall specify the evacuation capabilities of the patients as defined in the National Fire Protection Code (NFPA). This declaration will determine the design and construction requirements of the facility.

(26) Each ASTC shall ensure that an emergency keyed lock box is installed next to each bank of functioning elevators located on the main level. Such lock boxes shall be permanently mounted seventy-two inches (72") from the floor to the center of the box, be operable by a universal key no matter where such box is located, and shall contain only fire service keys and drop keys to the appropriate elevators.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-216, and 68-11-261.* ***Administrative History:*** *Original rule filed July 22, 1977; effective August 22, 1977. Amendment filed July 3, 1984; effective August 1, 1984. Repeal and new rule filed June 30, 1992; effective August 14, 1992. Repeal and new rule filed March 4, 2000; effective June 4, 2000. Amendment filed February 18, 2003; effective May 4, 2003. Amendment filed June 16, 2003; effective August 30, 2003. Repeal and new rule filed September 9, 2005; effective November 23, 2005. Amendment filed February 23, 2007; effective May 9, 2007. Repeal and new rule filed December 20, 2011; effective March 19, 2012. Amendment filed January 21, 2016; effective April 20, 2016.*

1200-08-10-.09 LIFE SAFETY.

(1) Any ambulatory surgical treatment center which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.

(2) The ambulatory surgical treatment center shall provide fire protection by the elimination of fire hazards, by the installation of necessary fire fighting equipment and by the adoption of a written fire control plan. All fires which result in a response by the local fire department shall be reported to the department within seven (7) days. The report shall contain sufficient information to ascertain the nature and location of the fire, its probable cause and any injuries incurred by any person or persons as a result of the fire. Initial reports by the facility may omit the name(s) of patient(s) and parties involved, however, should the department find the identities of such persons to be necessary to an investigation, the facility shall provide such information.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed July 22, 1977; effective August 22, 1997. Amendment filed July 3, 1984; effective August 1, 1984. Repeal and new rule filed June 30, 1992; effective August 14, 1992. Repeal and new rule filed March 21, 2000; effective June 4, 2000. Amendment filed June 16, 2003; effective August 30, 2003. Repeal and new rule filed September 9, 2005; effective November 23, 2005.*

1200-08-10-.10 INFECTIOUS AND HAZARDOUS WASTE.

(1) Each ambulatory surgical treatment center must develop, maintain and implement written policies and procedures for the definition and handling of its infectious and hazardous

(Rule 1200-08-10-.10, continued)

wastes, these policies and procedures must comply with the standards of this section and all other applicable state and federal regulations.

(2) The following waste shall be considered to be infectious waste:

(a) Waste contaminated by patients 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 (including but not limited to, hypodermic needles, syringes, pasteur pipettes, broken glass, scalpel blades) used in patient care or which have come into contact with infectious agents during use in medical, research, or industrial laboratories;

(f) Contaminated carcasses, body parts, and bedding of animals that were exposed to pathogens in research, in the production of biologicals, or in the in vivo testing of pharmaceuticals;

(g) Other waste determined to be infectious by the facility 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 facility.

(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.

(Rule 1200-08-10-.10, continued)

(5) After packaging, waste must be handled and transported by methods ensuring containment and preserving the integrity of the packaging, including the use of secondary containment where necessary.

(a) Waste must not be compacted or ground (i.e., in a mechanical grinder) prior to treatment, except that pathological waste may be ground prior to disposal;

(b) 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 facility 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 section; and

(c) Sanitize all contaminated equipment and surfaces appropriately. Written policies and procedure must specify how this will be done.

(d) Complete incident report and maintain copy on file.

(8) Except as provided otherwise in this section a facility must treat or dispose of infectious waste by one or more of the methods specified in this part.

(a) A facility 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 wastes treated in such a device are 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 conditions were met for proper sterilization or disinfection of materials included in the cycle, and records kept. Proper operation of such devices must be verified at least monthly, and records of these monthly checks 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 a 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.

(Rule 1200-08-10-.10, continued)

(b) The facility 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) The facility 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 facility 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 facility must notify in writing all public health agencies with jurisdiction that the location is being used for management of the facility'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 subparagraph. Any other human limbs and recognizable organs must be incinerated or discharged (following grinding) to the sewer.

(11) All garbage, trash and other non-infectious wastes shall be stored and disposed of in a manner that must not permit the transmission of disease, create a nuisance, provide a breeding place for insects and rodents, or constitute a safety hazard. All containers for waste shall be water tight, be constructed of easily cleanable material and be kept on elevated platforms.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed July 22, 1977; effective August 22, 1977. Amendment filed July 3, 1984; effective August 1, 1984. Repeal and new rule filed June 30, 1992; effective August 14, 1992. Repeal and new rule filed March 21, 2000; effective June 4, 2000. Amendment filed June 16, 2003; effective August 30, 2003. Amendment filed September 9, 2005; effective November 23, 2005.*

1200-08-10-.11 RECORDS AND REPORTS.

(1) The Joint Annual Report of Ambulatory Surgical Treatment Centers shall be filed with the department. The forms are furnished and mailed to each ASTC by the department each year and the forms must be completed and returned to the department as required.

(2) The facility shall report information contained in the medical records of patients who have cancer or pre-cancerous or tumorous diseases as provided by existing regulations. These reports shall be sent to the Cancer Reporting System of the department on a quarterly schedule no later than six (6) months after the date of the diagnosis or treatment.

(3) The ASTC shall report to the department each patient case of communicable disease detected in the center. Repeated failure to report communicable diseases shall be cause for revocation of an ASTC's license. The ASTC shall monitor outbreaks of communicable diseases in the nearby geographical area of the facility and inform the ASTC staff of these outbreaks in order for the employees to contact their personal physician for consultation regarding their vaccination status.

(Rule 1200-08-10-.11, continued)

(4) The ASTC shall report all incidents of abuse, neglect, and misappropriation to the Department of Health in accordance with T.C.A. § 68-11-211.

(5) The ASTC shall report the following incidents to the Department of Health in accordance with T.C.A. § 68-11-211.

(a) Strike by staff at the facility;

(b) External disasters impacting the facility;

(c) Disruption of any service vital to the continued safe operation of the ASTC or to the health and safety of its patients and personnel; and

(d) Fires at the ASTC that disrupt the provision of patient care services or cause harm to the patients or staff, or that are reported by the facility to any entity, including but not limited to a fire department charged with preventing fires.

(6) The ASTC shall retain legible copies of the following records and reports which shall be retained in the facility, shall be maintained in a single file, and shall be made available for inspection during normal business hours to any patient who requests to view them for thirty-six (36) months following their issuance:

(a) Local fire safety inspections;

(b) Local building code inspections, if any;

(c) Fire marshal reports;

(d) Department licensure and fire safety inspections and surveys;

(e) Department quality assurance surveys, including follow-up visits, and certification inspections, if any;

(f) Federal Health Care Financing Administration surveys and inspections, if any;

(g) Orders of the Commissioner or Board, if any;

(h) Comptroller of the Treasury's audit reports and finding, if any; and,

(i) Maintenance records of all safety equipment.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-1-1004, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, and 68-11-216.* ***Administrative History:*** *Original rule filed July 22, 1977; effective August 22, 1977. Amendment filed September 10, 1991; effective October 25, 1991. Repeal and new rule filed June 30, 1992; effective August 14, 1992. Repeal and new rule filed March 21, 2000; effective June 4, 2000. Amendment filed April 11, 2003; effective June 25, 2003. Amendments filed January 3, 2012; effective April 2, 2012. Amendments filed July 10, 2018; effective October 8, 2018.*

1200-08-10-.12 PATIENT RIGHTS.

(1) Each patient has at least the following rights:

(a) To privacy in treatment and personal care;

(Rule 1200-08-10-.12, continued)

(b) To be free from mental and physical abuse. Should this right be violated, the facility must notify the department within five (5) business days and the Tennessee Department of Human Services, Adult Protective Services immediately as required by T.C.A. §§ 71-6-101 et seq;

(c) To refuse treatment. The patient must be informed of the consequences of that decision, the refusal and its reason must be reported to the physician and documented in the medical record;

(d) To refuse experimental treatment and drugs. The patient's or health care decision maker's written consent for participation in research must be obtained and retained in his or her medical record;

(e) To have their records kept confidential and private. Written consent by the patient must be obtained prior to release of information except to persons authorized by law. If the patient lacks capacity, written consent is required from the patient's health care decision maker. The ambulatory surgical treatment center must have policies to govern access and duplication of the patient's record;

(f) To have appropriate assessment and management of pain; and

(g) To be involved in the decision making of all aspects of their care.

(2) Each patient has a right to self-determination, which encompasses the right to make choices regarding life-sustaining treatment (including resuscitative services). This right of self-determination may be effectuated by an advance directive.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed July 22, 1977; effective August 22, 1977. Repeal and new rule filed June 30, 1992; effective August 14, 1992. Repeal and new rule filed March 21, 2000; effective June 4, 2000. Amendment filed June 18, 2002; effective September 1, 2002. Amendment filed September 9, 2005; effective November 23, 2005.*

1200-08-10-.13 POLICIES AND PROCEDURES FOR HEALTH CARE DECISION-MAKING.

(1) Pursuant to this Rule, each ambulatory surgical treatment center shall maintain and establish policies and procedures governing the designation of a health care decision-maker for making health care decisions for a patient who is incompetent or who lacks capacity, including but not limited to allowing the withholding of CPR measures from individual patients. 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 patient could have made while having capacity, or may limit the power of the agent, and may include individual instructions. The effect of an advance directive that makes no limitation on the agent's authority shall be to authorize the agent to make any health care decision the patient could have made while having capacity.

(3) The advance directive shall be in writing, signed by the patient, 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 patient by blood, marriage, or adoption and would not be entitled to any portion of the

(Rule 1200-08-10-.13, continued)

estate of the patient upon the death of the patient. 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 authority of an agent becomes effective only upon a determination that the patient lacks capacity, and ceases to be effective upon a determination that the patient has recovered capacity.

(5) A facility may use any advanced directive form that meets the requirements of the Tennessee Health Care Decisions Act or has been developed and issued by the Board for Licensing Health Care Facilities.

(6) A determination that a patient lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent shall be made by the designated physician, who is authorized to consult with such other persons as he or she may deem appropriate.

(7) An agent shall make a health care decision in accordance with the patient'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 patient's best interest. In determining the patient's best interest, the agent shall consider the patient's personal values to the extent known.

(8) An advance directive may include the individual's nomination of a court-appointed guardian.

(9) A health care facility 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 patient'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 patient 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 patient 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 an 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 an earlier advance directive revokes the earlier directive to the extent of the conflict.

(16) Surrogates.

(Rule 1200-08-10-.13, continued)

(a) An adult or emancipated minor may designate any individual to act as surrogate by personally informing the supervising health care provider. The designation may be oral or written.

(b) A surrogate may make a health care decision for a patient who is an adult or emancipated minor if and only if:

1. The patient has been determined by the designated physician to lack capacity, and

2. No agent or guardian has been appointed, or

3. The agent or guardian is not reasonably available.

(c) In the case of a patient who lacks capacity, the patient's surrogate shall be identified by the supervising health care provider and documented in the current clinical record of the facility at which the patient is receiving health care.

(d) The patient's surrogate shall be an adult who has exhibited special care and concern for the patient, who is familiar with the patient'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 patient's spouse, unless legally separated;

2. The patient's adult child;

3. The patient's parent;

4. The patient's adult sibling;

5. Any other adult relative of the patient; or

6. Any other adult who satisfies the requirements of 1200-08-10-.13(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 patient shall be eligible to serve as the patient'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 known wishes of the patient or in accordance with the patient's best interests;

2. The proposed surrogate's regular contact with the patient 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 patient during his or her illness; and

(Rule 1200-08-10-.13, continued)

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 patient lacks capacity and none of the individuals eligible to act as a surrogate under 1200-08-10-.13(16)(c) through 1200-08-10-.13(16)(g) is reasonably available, the designated physician may make health care decisions for the patient 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 patient'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 patient'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 patient's best interest. In determining the patient's best interest, the surrogate shall consider the patient's personal values to the extent known to the surrogate.

(k) A surrogate who has not been designated by the patient may make all health care decisions for the patient that the patient could make on the patient's own behalf, except that artificial nutrition and hydration may be withheld or withdrawn for a patient upon a decision of the surrogate only when the designated physician and a second independent physician certify in the patient's current clinical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the patient is highly unlikely to regain capacity to make medical decisions.

(l) Except as provided in 1200-08-10-.13(16)(m):

1. Neither the treating health care provider nor an employee of the treating health care provider, nor an operator of a health care institution nor an employee of an operator of a health care institution may be designated as a surrogate; 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 patient's treating health care provider.

(m) An employee of the treating health care provider or an employee of an operator of a health care institution may be designated as a surrogate if:

1. The employee so designated is a relative of the patient by blood, marriage, or adoption; and

2. The other requirements of this section are satisfied.

(Rule 1200-08-10-.13, continued)

(n) A health care provider may require an individual claiming the right to act as surrogate for a patient to provide written documentation stating facts and circumstances reasonably sufficient to establish the claimed authority.

(17) Guardian.

(a) A guardian shall comply with the patient's individual instructions and may not revoke the patient'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 patient 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 patient 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 the determination in the patient's current clinical record and communicate the determination to the patient, if possible, and to any person then authorized to make health care decisions for the patient.

(19) Except as provided in 1200-08-10-.13(20) through 1200-08-10-.13(22), a health care provider or institution providing care to a patient shall:

(a) Comply with an individual instruction of the patient and with a reasonable interpretation of that instruction made by a person then authorized to make health care decisions for the patient; and

(b) Comply with a health care decision for the patient made by a person then authorized to make health care decisions for the patient to the same extent as if the decision had been made by the patient 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 a policy of the institution which is based on reasons of conscience, and

(b) The policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient.

(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 1200-08-10-.13(20) through 1200-08-10-.13(22) shall:

(a) Promptly so inform the patient, if possible, and any person then authorized to make health care decisions for the patient;

(Rule 1200-08-10-.13, continued)

(b) Provide continuing care to the patient until a transfer can be effected or until the determination has been made that transfer cannot be effected;

(c) Unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision; 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 patient has the same rights as the patient 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 patient, 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 for such identification 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 patient 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) Physician Orders for Scope of Treatment (POST)

(a) Physician Orders for Scope of Treatment (POST) may be issued by a physician for a patient with whom the physician has a bona fide physician-patient relationship, but only:

1. With the informed consent of the patient;

2. If the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon 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

(Rule 1200-08-10-.13, continued)

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, if the physician determines that the provision of cardio pulmonary resuscitation would be contrary to accepted medical standards.

(b) A POST may be issued by a physician assistant, nurse practitioner or clinical nurse specialist for a patient with whom such physician assistant, nurse practitioner or clinical nurse specialist has a bona fide physician assistant-patient or nurse-patient relationship, but only if:

1. No physician, who has a bona fide physician-patient relationship with the patient, is present and available for discussion with the patient (or if the patient is a minor or is otherwise incapable of making an informed decision, with the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act);

2. Such authority to issue is contained in the physician assistant's, nurse practitioner's or clinical nurse specialist's protocols;

3. Either:

(i) The patient is a resident of a nursing home licensed under title 68 or an ICF/MR facility licensed under title 33 and is in the process of being discharged from the nursing home or transferred to another facility at the time the POST is being issued; or

(ii) The patient is a hospital patient and is in the process of being discharged from the hospital or transferred to another facility at the time the POST is being issued; and

4. Either:

(i) With the informed consent of the patient;

(ii) If the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon 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

(iii) 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 and such authority to issue is contained in the physician assistant, nurse practitioner or clinical nurse specialist's protocols and the physician assistant or nurse determines that the provision of cardiopulmonary resuscitation would be contrary to accepted medical standards.

(c) If the patient is an adult who is capable of making an informed decision, the patient's expression of the desire to be resuscitated in the event of cardiac or respiratory arrest shall revoke any contrary order in the POST. If the patient is a minor or is otherwise incapable of making an informed decision, the expression of the desire that the patient be resuscitated by the person authorized to consent on the patient's behalf shall revoke

(Rule 1200-08-10-.13, continued)

any contrary order in the POST. Nothing in this section shall be construed to require cardiopulmonary resuscitation of a patient for whom the physician or physician assistant or nurse practitioner or clinical nurse specialist determines cardiopulmonary resuscitation is not medically appropriate.

(d) A POST issued in accordance with this section shall remain valid and in effect until revoked. In accordance with this rule and applicable regulations, 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, the Department of Mental Health and Substance Abuse Services, or the Department of Intellectual and Developmental Disabilities, or operated, licensed, or owned by another state agency, shall follow a POST that is available to such persons in a form approved by the Board for Licensing Health Care Facilities.

(e) Nothing in these rules shall authorize the withholding of other medical interventions, such as medications, positioning, wound care, oxygen, suction, treatment of airway obstruction or other therapies deemed necessary to provide comfort care or alleviate pain.

(f) If a person has a do-not-resuscitate order in effect at the time of such person's discharge from a health care facility, the facility shall complete a POST prior to discharge. If a person with a POST 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 POST to qualified emergency medical service personnel and to the receiving facility prior to the transfer. The transferring facility shall provide a copy of the POST that accompanies the patient in transport to the receiving health care facility. Upon admission, the receiving facility shall make the POST a part of the patient's record.

(g) These rules shall not prevent, prohibit, or limit a physician from using a written order, other than a POST, not to resuscitate a patient in the event of cardiac or respiratory arrest in accordance with accepted medical practices. This action shall have no application to any do not resuscitate order that is not a POST, as defined in these rules.

(h) Valid do not resuscitate orders or emergency medical services do not resuscitate orders issued before July 1, 2004, pursuant to then-current law, shall remain valid and shall be given effect as provided in these rules.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-224, and 68-11-1801 through 68-11-1815.* ***Administrative History:*** *Original rule filed June 22, 1992; effective August 6, 1992. Repeal and new rule filed March 21, 2000; effective June 4, 2000. Amendment filed April 28, 2003; effective July 12, 2003. Repeal and new rule filed September 9, 2005; effective November 23, 2005. Amendment filed February 7, 2007; effective April 23, 2007. Amendments filed January 3, 2012; effective April 2, 2012. Amendment filed March 27, 2015; effective June 25, 2015.*

1200-08-10-.14 DISASTER PREPAREDNESS.

(1) The administration of every facility shall have in effect and available for all supervisory personnel and staff, written copies of the following required disaster plans for the protection of all persons in the event of fire and other emergencies for evacuation to areas of refuge and/or evacuation from the building. A detailed log with staff signatures of training received shall be maintained. All employees shall be trained annually as required in the following plans and shall be kept informed with respect to their duties under the plans. A copy of the

(Rule 1200-08-10-.14, continued)

plans and the specific emergency numbers related to that type of disaster shall be readily available at all times. Each of the following plans shall be exercised annually:

(a) Fire Safety Procedures Plan shall include:

1. Minor fires;
2. Major fires;
3. Fighting the fire;
4. Evacuation procedures;
5. Staff functions.

(b) Tornado/Severe Weather Procedures Plan shall include:

1. Staff duties;
2. Evacuation procedures.

(c) Flood Procedure Plan, if applicable:

1. Staff duties;
2. Evacuation procedures;
3. Safety procedures following the flood.

(d) Earthquake Disaster Procedures Plan:

1. Staff duties;
2. Evacuation procedures;
3. Safety procedures;
4. Emergency services.

(2) All facilities shall participate in the Tennessee Emergency Management Agency local/county emergency plan on an annual basis. Participation includes filling out and submitting a questionnaire on a form to be provided by the Tennessee Emergency Management Agency. Documentation of participation must be maintained and shall be made available to survey staff as proof of participation.

(3) The emergency power system shall:

(a) Use either propane, gasoline or diesel fuel. The generator shall be designed to meet the facility's HVAC and essential needs and shall have a minimum of twenty-four (24) hours of fuel designed to operate at its rated load. The fuel quantity shall be based on its expected or known connected load consumption during power interruptions.

(b) Automatically transfer within ten (10) seconds in ASTC's conducting invasive surgical procedures.

(Rule 1200-08-10-.14, continued)

(c) Be inspected monthly and exercised at the actual load and operating temperature conditions and not on dual power for at least thirty (30) minutes each month, including automatic and manual transfer of equipment. A log shall be maintained for all inspections and tests and kept on file for a minimum of three (3) years. The facility shall have trained staff familiar with the generator's operation.

(d) Emergency generators are not required if the facility does not utilize anesthesia that renders the patient incapable of self preservation. However, the facility shall have an emergency power source able to produce adequate power to run required equipment for a minimum of two (2) hours.

(4) Emergency electrical power connections shall be through a switch which shall automatically transfer the circuits to the emergency power source in case of power failure. (It is recognized that some equipment may not sustain automatic transfer and provisions will have to be made to manually change these items from a non-emergency powered outlet to an emergency powered outlet or other power source.)

(5) In the event of natural disaster or electrical power failure, no new surgical procedures shall be begun, and surgical procedures in progress shall be brought to conclusion as soon as possible.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.* ***Administrative History:*** *Original rule filed November 22, 1996; effective August 27, 1997. Repeal and new rule filed March 21, 2000; effective June 4, 2000. Amendment filed June 16, 2003; effective August 30, 2003.*

1200-08-10-.15 APPENDIX I

(1) Physician Orders for Scope of Treatment (POST) Form

A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED		
Tennessee Physician Orders for Scope of Treatment (POST, sometimes called "POLST") 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 is not breathing.** ☐ **Resuscitate(CPR)** ☐ **Do Not Attempt Resuscitation (DNR / no CPR) (Allow Natural Death)** When not in cardiopulmonary arrest, follow orders in **B, C,** and **D.**	

(Rule 1200-08-10-.15, continued)

Section B *Check One Box Only*	**MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing.** ☐ **Comfort Measures Only.** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. 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. Treatment Plan: Maximize comfort through symptom management.** ☐ **Limited Additional Interventions.** In addition to care described in Comfort Measures Only above, use medical treatment, antibiotics, IV fluids and cardiac monitoring as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). **Transfer** to hospital if indicated. Generally avoid the intensive care unit. **Treatment Plan: basic medical treatments.** ☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. **Transfer** to hospital and/or intensive care unit if indicated. **Treatment Plan: Full treatment including in the intensive care unit.** *Other Instructions:*_____
Section C *Check One*	**ARTIFICIALLY ADMINISTERED NUTRITION. Oral fluids & nutrition must be offered if feasible.** ☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube. ☐ Long-term artificial nutrition by tube. *Other Instructions:*_____

Section D *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/NP/CNS/PA Name (Print)	**Physician/NP/CNS/PA Signature Date** NP/CNS/PA (Signature at Discharge)	**MD/NP/CNS/PA Phone Number:**

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician and/or health care professional. It can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)

Agent/Surrogate	Relationship	Phone Number

Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

(Rule 1200-08-10-.15, continued)

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.

To be valid, POST must be signed by a physician or, at discharge or transfer from a hospital or long term care facility, by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Persons with DNR in effect at time of discharge must have POST completed by health care facility prior to discharge and copy of POST provided to qualified medical emergency personnel.

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 Health Care Agent or 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 D and write "VOID" in large letters if POST is replaced or becomes invalid.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

(2) Advance Directive for Health Care Form

ADVANCE DIRECTIVE FOR HEALTH CARE* (Tennessee)

Instructions: Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

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

(Rule 1200-08-10-.15, continued)
decisions myself.

Part I Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____ Home Phone: _____ Work Phone: _____
Address: _____ Mobile Phone: _____ Other Phone: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____ Home Phone: _____ Work Phone: _____
Address: _____ Mobile Phone: _____ Other Phone: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Part 2 Indicate Your Wishes for Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**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.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Indicate Your Wishes for Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ 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.

(Rule 1200-08-10-.15, continued)

☐ Yes	☐ No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Part 3 **Other instructions, such as hospice care, burial arrangements, etc.:** _____

(Attach additional pages if necessary)

Part 4 **Organ donation:** Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

☐ No organ/tissue donation

SIGNATURE

Part 5 Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: _____ Date: _____
(Patient)

Block A Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent or alternate. 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 or alternate. 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

Block B You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

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.

(Rule 1200-08-10-.15, continued)

My commission expires: _____

_____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE: (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.* ***Administrative History****: Original rule filed February 16, 2007; effective May 2, 2007. Repeal and new rule filed August 28, 2012; effective November 26, 2012. Amendment filed March 27, 2015; effective June 25, 2015. Amendments filed February 8, 2017; effective May 9, 2017.*

RULES
OF
TENNESSEE DEPARTMENT OF HEALTH
BOARD FOR LICENSING HEALTH CARE FACILITIES

CHAPTER 1200-08-11
STANDARDS FOR HOMES FOR THE AGED

TABLE OF CONTENTS

1200-08-11-.01 DEFINITIONS.

(1) Abuse. The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.

(2) Activities of Daily Living (ADL's). Those personal functional activities which indicate an individual's independence in eating, dressing, personal hygiene, bathing, toileting, and moving from one place to another.

(3) Adult. An individual who has capacity and is at least 18 years of age.

(4) Advance Directive. An individual instruction or a written statement relating to the subsequent provision of health care for the individual, including, but not limited to, a living will or a durable power of attorney for health care.

(5) Aged. A person who is fifty-five (55) years of age or older.

(6) Agent. An individual designated in an advance directive for health care to make a health care decision for the individual granting the power.

(7) Ambulatory resident. A resident who is physically and mentally capable under emergency conditions of finding a way to safety without physical assistance from another person. An ambulatory resident may use a cane, wheelchair or other supportive device and may require verbal prompting.

(8) Board. The Tennessee Board for Licensing Health Care Facilities.

(9) Capacity. An individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision. These regulations do not affect the right of a resident to make health care decisions while having the capacity to do so. A resident shall be presumed to have capacity to make a health care decision, to give or revoke an advance directive, and to designate or disqualify a surrogate. Any person who challenges the capacity of a resident shall have the burden of proving lack of capacity.

(10) Cardiopulmonary Resuscitation (CPR). The administering of any means or device to restore or support cardiopulmonary function in a resident, whether by mechanical devices, chest compressions, mouth-to-mouth resuscitation, cardiac massage, tracheal intubation, manual

(Rule 1200-08-11-.01, continued)

or mechanical ventilators or respirations, defibrillation, the administration of drugs and/or chemical agents intended to restore cardiac and/or respiratory functions in a resident where cardiac or respiratory arrest has occurred or is believed to be imminent.

(11) Commissioner. The Commissioner of the Tennessee Department of Health or his or her authorized representative.

(12) Department. The Tennessee Department of Health.

(13) Designated Physician. A physician designated by an individual or the individual's agent, guardian, or surrogate, to have primary responsibility for the individual's health care or, in the absence of designation or if the designated physician is not reasonably available, a physician who undertakes such responsibility.

(14) Do-Not-Resuscitate Order (DNR). A written order, other than a POST, not to resuscitate a patient in cardiac or respiratory arrest in accordance with accepted medical practices.

(15) Emancipated Minor. Any minor who is or has been married or has by court order or otherwise been freed from the care, custody and control of the minor's parents.

(16) Emergency. Any situation or condition which presents an imminent danger of death or serious physical or mental harm to residents.

(17) Emergency responder. A paid or volunteer firefighter, law enforcement officer, or other public safety official or volunteer acting within the scope of his or her proper function under law or rendering emergency care at the scene of an emergency.

(18) Evacuation Capability. The ability to either evacuate the building or move to a point of safety.

(19) Guardian. A judicially appointed guardian of conservator having authority to make a health care decision

(20) Hazardous Waste. Materials whose handling, use, storage, and disposal are governed by local, state, or federal regulations.

(21) Health Care. Any care, treatment, service or procedure to maintain, diagnose, treat, or otherwise affect an individual's physical or mental condition, and includes medical care as defined in T.C.A. § 32-11-103(5)

(22) Health care decision. Consent, refusal or consent or withdrawal of consent to health care.

(23) Health Care Decision-maker. In the case of a resident who lacks capacity, the resident's health care decision-maker is one of the following: the resident's health care agent as specified in an advance directive, the resident's court-appointed guardian or conservator with healthcare decision-making authority, the resident's surrogate as determined pursuant to Rule 1200-08-11-.12 or T.C.A. § 33-3-220, the designated physician pursuant to these Rules or in the case of a minor child, the person having custody or legal guardianship.

(24) Health Care Institution. A health care institution as defined in T.C.A. § 68-11-1602.

(25) Health Care Provider. A person who iss~~i~~ licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care in the ordinary course of business or practice of a profession.

(Rule 1200-08-11-.01, continued)

(26) Holding Out to the Public. Advertising or soliciting the public through the use of personal, telephone, mail or other forms of communication to provide information about services provided by the facility.

(27) Home for the Aged. A home represented and held out to the general public as a home which accepts primarily aged persons for relatively permanent, domiciliary care with primarily being defined as 51% or more of the population of the home for the aged. It provides room, board and personal services to four (4) or more nonrelated persons. The term home includes any building or part thereof which provides services as defined in these rules.

(28) Home for the Aged Resident. A person who is ambulatory and who requires permanent, domiciliary care but who will be transferred to a licensed hospital, licensed nursing home or licensed assisted care living facility when health care services are needed which must be provided in such other facilities.

(29) Incompetent. A resident who has been adjudicated incompetent by a court of competent jurisdiction and has not been restored to legal capacity.

(28) Individual instruction. An individual's direction concerning a health care decision for the individual.

(30) Infectious Waste. Solid or liquid wastes which contain pathogens with sufficient virulence and quantity such that exposure to the waste by a susceptible host could result in an infectious disease.

(31) Licensee. The person or entity to whom the license is issued. The licensee is held responsible for compliance with all rules and regulations.

(32) Life Threatening r~~O~~r Serious Injury. Injury requiring the patient to undergo significant additional diagnostic or treatment measures.

(33) Medically Inappropriate Treatment –Resuscitation efforts that cannot be expected either to restore cardiac or respiratory function to the resident or other medical or surgical treatments to achieve the expressed goals of the informed resident. In the case of the incompetent resident, the resident's representative expresses the goals of the resident

(34) N.F.P.A. The National Fire Protection Association.

(35) Misappropriation of Patient/Resident Property. The deliberate misplacement, exploitation or wrongful, temporary or permanent use of an individual's belongings or money without the individual's consent.

(36) Neglect. The failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness; however, the withholding of authorization for or provision of medical care to any terminally ill person who has executed an irrevocable living will in accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of the living will, shall not be deemed "neglect" for purposes of these rules.

(37) Person. An individual, corporation, estate, trust, partnership, association, joint venture, government, governmental subdivision, agency or instrumentality, or any other legal or commercial entity.

(38) Personal Services. Those services that are rendered to residents who need supervision or assistance in activities of daily living. Personal services must include protective care of the resident, responsibility for the safety of the resident when in the facility, daily awareness of

(Rule 1200-08-11-.01, continued)

the resident's whereabouts and the ability and readiness to intervene if crises arise. Personal services do not include nursing or medical care.

(39) Personally Informing. A communication by any effective means from the resident directly to a health care provider.

(40) Physician Assistant. A person who has graduated from a physician assistant educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant, has passed the Physician Assistant National Certifying Examination, and is currently licensed in Tennessee as a physician assistant under title 63, chapter 19.

(41) Physician Orders for Scope of Treatment or POST. Written orders that:

(a) Are on a form approved by the Board for Licensing Health Care Facilities;

(b) Apply regardless of the treatment setting and that are signed as required herein by the patient's physician, physician assistant, nurse practitioner, or clinical nurse specialist; and

(c)

1. Specify whether, in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should or should not be attempted;

2. Specify other medical interventions that are to be provided or withheld; or

3. Specify both 1 and 2.

(42) Power of Attorney for Health Care. The designation of an agent to make health care decisions for the individual granting the power under T.C.A. Title 34, Chapter 6, Part 2.

(43) Qualified Emergency Medical Service Personnel. Includes, but shall not be limited to, emergency services personnel providers, or entities acting within the usual course of their professions, and other emergency responders.

(44) Reasonably Available. Readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the resident's health care needs. Such availability shall include, but not limited to, availability by telephone.

(45) Responsible Attendant. The person designated by the licensee who remains awake to provide personal services to the residents. In the absence of the licensee, the responsible attendant is responsible for ensuring the home complies with all rules and regulations.

(46) Secured Unit. A facility or distinct part of a facility where the residents are intentionally denied egress by any means.

(47) Shall or Must. Compliance is mandatory.

(48) State. A state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.

(49) Supervising Heath Care Provider. The designated physician or, if there is no designated physician or~~t~~ the designated physician is not reasonably available, the health care provider who has undertaken primary responsibility for an individual's health care.

(Rule 1200-08-11-.01, continued)

(50) Surrogate. An individual, other that a resident's agent or guardian, authorized to make a health care decision for the resident.

(51) Treating Health Care Provider. A health care provider who at the time is directly or indirectly involved in providing health care to the resident.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 39-11-106, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-216, 68-11-224, and 68-11-1802.* ***Administrative History:*** *Original rule filed June 21, 1979; effective August 6, 1979. Amendment filed August 16, 1988; effective September 30, 1988. Amendment filed January 30, 1992; effective March 15, 1992. Amendment filed December 7, 1993; effective February 20, 1994. Repeal and new rule filed July 27, 2000; effective October 10, 2000. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed April 28, 2003; effective July 12, 2003.Amendment filed September 8, 2006; effective November 22, 2006. Amendment filed February 7, 2007; effective April 23, 2007. Amendment filed February 23, 2007; effective May 9, 2007. Amendment filed January 3, 2012; effective April 2, 2012. Amendment filed March 27, 2015; effective June 25, 2015. Amendments filed July 10, 2018; effective October 8, 2018.*

1200-08-11-.02 LICENSING PROCEDURES.

(1) No person, partnership, association, corporation, or state, county or local government unit, or any division, department, board or agency thereof, shall establish, conduct, operate, or maintain in the State of Tennessee any home for the aged without having a license. A license shall be issued only to the applicant named and only for the premises listed in the application for licensure. Licenses are not transferable or assignable and shall expire and become invalid annually on the anniversary date of their original issuance. The license shall be conspicuously posted in the home for the aged.

(2) In order to make application for a license:

(a) The applicant shall submit an application on a form prepared by the department.

(b) Each applicant for a license shall pay an annual license fee based on the number of beds as follows:

1.	Less than 6 beds	$ 390.00
2.	6 to 24 beds, inclusive	$ 1,040.00
3.	25 to 49 beds, inclusive	$ 1,300.00
4.	50 to 74 beds, inclusive	$ 1,560.00
5.	75 to 99 beds, inclusive	$ 1,820.00
6.	100 to 124 beds, inclusive	$ 2,080.00
7.	125 to 149 beds, inclusive	$ 2,340.00
8.	150 to 174 beds, inclusive	$ 2,600.00
9.	175 to 199 beds, inclusive	$ 2,860.00

For homes for the aged of two hundred (200) beds or more the fee shall be two thousand eight hundred and sixty dollars ($2,860.00) plus two hundred dollars ($200.00) for each twenty-five (25) beds or fraction thereof in excess of one hundred

(Rule 1200-08-11-.02, continued)

ninety-nine (199) beds. The fee shall be submitted with the application or renewal and is not refundable.

(c) The issuance of an application form is in no way a guarantee that the completed application will be accepted or that a license will be issued by the department. Residents shall not be admitted to the home until a license has been issued. Applicants shall not hold themselves out to the public as being a home for the aged until the license has been issued. A license shall not be issued until the facility is in substantial compliance with these rules.

(d) The applicant must prove the ability to meet the financial needs of the facility.

(e) The applicant shall not use subterfuge or other evasive means to obtain a license, such as filing for a license through a second party when an individual has been denied a license or has had a license disciplined or has attempted to avoid inspection and review process.

(f) The applicant shall allow the residential home for the aged to be inspected by a Department surveyor. In the event that deficiencies are noted, the applicant shall submit a plan of corrective action to the Board that must be accepted by the Board. Once the deficiencies have been corrected, then the Board shall consider the application for licensure.

(3) A proposed change of ownership, including a change in a controlling interest, must be reported to the department a minimum of thirty (30) days prior to the change. A new application and fee must be received by the department before the license may be issued.

(a) For the purpose of licensing, the licensee of a home for the aged has the ultimate responsibility for the operation of the facility, including the final authority to make or control operational decisions and legal responsibility for the business management. A change of ownership occurs whenever this ultimate legal authority for the responsibility of the home's operation is transferred.

(b) A change of ownership occurs whenever there is a change in the legal structure by which the home is owned and operated.

(c) Transactions constituting a change of ownership include, but are not limited to, the following:

1. Transfer of the facility's legal title;

2. Lease of the facility's operations;

3. Dissolution of any partnership that owns, or owns a controlling interest in, the facility;

4. One partnership is replaced by another through the removal, addition or substitution of a partner;

5. Removal of the general partner or general partners, if the facility is owned by a limited partnership;

6. Merger of a facility 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 facility 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. Two (2) or more corporations merge and the originally-licensed corporation survives;

3. Changes in the membership of a non-profit corporation;

4. Transfers between departments of the same level of government; or

5. Corporate stock transfers or sales, even when a controlling interest.

(e) Management agreements are generally not changes of ownership if the owner continues to retain ultimate authority for the operation of the facility. However, if the ultimate authority is surrendered and transferred from the owner to a new manager, then a change of ownership has occurred.

(f) Sale/lease-back agreements shall not be treated as changes in ownership if the lease involves the facility's entire real and personal property and if the identity of the leasee, who shall continue the operation, retains the exact same legal form as the former owner.

(4) Renewal.

(a) In order to renew a license, each residential home for the aged shall submit to periodic inspections by Department surveyors for compliance with these rules. If deficiencies are noted, the licensee shall submit an acceptable plan of corrective action and shall remedy the deficiencies. In addition, each licensee shall submit a renewal form approved by the board and applicable renewal fee prior to the expiration date of the license.

(b) If a licensee fails to renew its license prior to the date of its expiration but submits the renewal form and fee within sixty (60) days thereafter, the licensee may renew late by paying, in addition to the renewal fee, a late penalty of one hundred dollars ($100) per month for each month or fraction of a month that renewal is late; provided that the late penalty shall not exceed twice the renewal fe~~e~~e.

(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 1200-08-11-.02(2)(b).

(d) Upon reapplication, the licensee shall submit to an inspection of the facility by Department of Health surveyors.

(5) A license shall be issued only for the location designated and the licensee named in the application. If a home moves to a new location, a new license will be required before

(Rule 1200-08-11-.02, continued)

residents are admitted. A licensee who plans to relocate must contact the department to inspect the new building prior to relocation.

(6) Any admission in excess of the licensed bed capacity is prohibited.

(7) A separate license shall be required for each home for the aged when more than one home is operated under the same management or ownership.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-209(a)(1), 68-11-210, 68-11-216, Chapter 846 of the Public Acts of 2008, § 1, and T.C.A. § 68-11-206(a)(5) [effective January 1, 2009].* ***Administrative History:*** *Original rule filed June 21, 1979; effective August 6, 1997. Amendment filed August 16, 1988; effective September 30, 1988. Amendment filed January 30, 1992; effective March 15, 1992. Repeal and new rule filed July 27, 2000; effective October 10, 2000. Amendment filed November 19, 2003; effective February 2, 2004. Amendment filed September 8, 2006; effective November 22, 2006. Amendment filed January 19, 2007; effective April 4, 2007. Public necessity rules filed April 29, 2009; effective through October 11, 2009. Emergency rules filed October 9, 2009; effective through April 7, 2010. Amendments filed September 24, 2009; effective December 23, 2009. Amendment filed December 16, 2013; effective March 16, 2014. Amendments filed March 21, 2018; to have been effective June 19, 2018. However, on May 24, 2018, the Government Operations Committee filed a 5-day stay; new effective date June 24, 2018.*

1200-08-11-.03 DISCIPLINARY PROCEDURES.

(1) The board may suspend or revoke a license for:

(a) Violation of state statutes;

(b) Violation of the rules as set forth in this chapter;

(c) Permitting, aiding or abetting the commission of any illegal act in the home;

(d) Conduct or practice found by the board to be detrimental to the health, safety, or welfare of the residents of the home; and

(e) Failure to renew the license.

(2) The board may consider all factors which it deems relevant, including but not limited to the following, when determining sanctions:

(a) The degree of sanctions necessary to ensure immediate and continued compliance;

(b) The character and degree of impact of the violation on the health, safety and welfare of the residents in the home;

(c) The conduct of the home in taking all feasible steps or procedures necessary or appropriate to comply or correct the violation; and

(d) Any prior violations by the home of statutes, rules or orders of the Commissioner or the board.

(3) Failure to timely submit an acceptable plan of correction shall subject the home’s license to possible disciplinary action.

(4) The Commissioner may suspend the admission of any new residents to the home, pending a prompt hearing before the board or an administrative law judge, when the conditions are or are likely to be detrimental to the health, safety or welfare of the residents.

(Rule 1200-08-11-.03, continued)

(5) Whenever the Commissioner suspends the admission of any new residents to the home because of the detrimental conditions found, the home shall post a copy of the Commissioner's Order upon the public entrance doors of the facility and prominently display it there for so long as it remains effective and until the Commissioner or the board removes the suspension and restores the facility's ability to admit new residents. During the suspension, the home shall inform any person who inquires about the admission of a new resident of the provisions of the order and make a copy of the order available for the inquirer's inspection.

(6) Following a contested case hearing, the board may find a facility's license subject to suspension or revocation and may then immediately impose any sanction authorized by law.

(7) The board may recommend the appointment of one or more special monitors to serve such term and to be present in the home for such hours each week as the board finds necessary and appropriate, as specified in its order. The home shall reimburse the reasonable fees and expenses of any special monitor so appointed by the board.

(8) Any licensee or applicant for a license, aggrieved by a decision or action of the department or board, pursuant to this rule, may request a hearing before the board. The proceedings and judicial review of the board's decision shall be in accordance with the Uniform Procedures Act, T.C.A. §§ 4-5-101, et seq.

(9) Reconsideration and Stays. The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-04-01-.18 regarding petitions for reconsiderations and stays in that case.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 4-5-219, 4-5-312, 4-5-316, 4-5-317, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-208, 68-11-209, and 68-11-221.* ***Administrative History:*** *Original rule filed June 21, 1979; effective August 6, 1979. Amendment filed August 16, 1988; effective September 30, 1988. Repeal and new rule filed July 27, 2000; effective October 10, 2000. Amendment filed March 1, 2007; effective May 15, 2007.*

1200-08-11-.04 ADMINISTRATION.

(1) 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.

(2) 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.

(3) Each home must have an administrator who shall be certified by the board, unless the administrator is currently licensed in Tennessee as a nursing home administrator pursuant to T.C.A. §§ 63-16-101, et seq.

(4) An applicant for certification as a home for the aged administrator shall meet the following requirements:

(a) Must be at least eighteen (18) years of age and a high school graduate or the holder of a general equivalency diploma.

(b) Must not have been convicted of a criminal offense involving the abuse or intentional neglect of an elderly or vulnerable individual.

(c) Must submit an application, on a form provided by the department, and a fee of one hundred eighty dollars ($180) prior to issuance or renewal of a certificate. All certificates shall expire biennially on June 30, thereafter.

(d) Biennial renewal of certification is required. The renewal application and fee of one hundred eighty dollars ($180) shall be submitted with written proof of attendance, during the period prior to renewal, of at least twenty-four (24) classroom hours of continuing education courses. The initial biennial re-certification expiration date of Home for the Aged administrator candidates who receive their initial administrator 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. The extension applies only to the first biennial certification period for any such administrator and may only be applied when there are less than six (6) months remaining in the State fiscal year.

(e) Continuing education.

1. The twenty-four (24) classroom hours of required continuing education courses shall include instruction in the following:

(i) State rules and regulations for homes for the aged;

(ii) Health care management;

(iii) Nutrition and food service;

(iv) Financial management; and

(v) Healthy lifestyles.

2. All educational courses must be approved by the board. Courses sponsored by the National Association of Residential Care Facilities and the National Association of Nursing Home Administrators are deemed approved by the board.

3. In order to obtain board approval for educational courses, a copy of the course curriculum must be submitted to the board for approval prior to attending the course.

4. Proof of administrator certification course attendance shall be submitted to the department upon completion of the course.

(5) Infection Control. A Home for the Aged shall have an annual influenza vaccination program which shall include at least:

(a) The offer of influenza vaccination to all staff and independent practitioners at no cost to the person or acceptance of documented evidence of vaccination from another vaccine source or facility. The Home for the Aged will encourage all staff and independent practitioners to obtain an influenza vaccination;

(b) A signed declination statement on record from all who refuse the influenza vaccination for reasons other than medical contraindications (a sample form is available at https://www.tn.gov/content/dam/tn/health/documents/SampleIndividualFluForm.pdf);

(c) Education of all employees about the following:

(Rule 1200-08-11-.04, continued)

1. Flu vaccination,

2. Non-vaccine control measures, and

3. The diagnosis, transmission, and potential impact of influenza;

(d) An annual evaluation of the influenza vaccination program and reasons for non-participation; and

(e) A statement that the requirements to complete vaccinations or declination statements shall be suspended by the administrator in the event of a vaccine shortage as declared by the Commissioner or the Commissioner's designee.

(6) Each home for the aged shall:

(a) Have an identified responsible attendant and a sufficient number of employees to meet the needs of the residents. The responsible attendant must be at least eighteen (18) years of age and able to comply with these rules.

(b) Have a responsible awake attendant on the premises at all times.

(c) Maintain documentation of the checks of the "Registry of Persons who have Abused or Intentionally Neglected Elderly or Vulnerable Individuals" prior to hiring any employee.

(d) Have a written statement of policies and procedures outlining the responsibilities of the licensee to the resident and any obligation of the resident to the facility.

(e) Post whether they have 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 displayed at the main public entrance.

(f) Keep a written up-to-date log of all residents and produce the log for the local fire department in the event of an emergency.

(g) Maintain written policies and procedures informing the resident of his/her rights and how to register grievances and complaints.

(h) Not allow an owner, responsible attendant, employee or representative thereof to act as a court-appointed guardian, trustee, or conservator for any resident of the facility or any of such resident's property or funds, except as provided by rule 1200-08-11-.10.

(i) Cooperate in the Department's inspections including allowing entry at any hour and providing all required records.

(j) Develop and follow a written policy, plan, procedure, technique or system regarding a subject whenever these rules require that a licensee develop such a plan. A residential home which violates a required policy also violates the rule establishing the requirements.

(k) 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, Adult Protective Services, the Comptroller of the State Treasury or the Long Term Care Ombudsman Program. A home shall neither retaliate nor discriminate because of information lawfully provided to these authorities, because of a person's cooperation

(Rule 1200-08-11-.04, continued)

with them or because a person is subpoenaed to testify at a hearing involving one of these authorities.

(l) Allow pets in the home only when they are not a nuisance or do not pose a health hazard.

(m) Comply with all local laws, rules or ordinances, and with this chapter.

(n) The facility shall develop a concise statement of its charity care policies and shall post such statement in a place accessible to the public.

(7) No occupant or employee who has a reportable communicable disease, as stipulated by the department, is permitted to reside or work in a home unless the home has a written protocol approved by the department.

(8) All health care facilities licensed pursuant to T.C.A. §§ 68-11-201, et seq. shall post the following in the main public entrance:

(a) Contact information including statewide toll-free number of the division of adult protective services, and the number for the local district attorney's office;

(b) A statement that a person of advanced age who may be the victim of abuse, neglect, or exploitation may seek assistance or file a complaint with the division concerning abuse, neglect and exploitation; and

(c) A statement that any person, regardless of age, who may be the victim of domestic violence may call the nationwide domestic violence hotline, with that number printed in boldface type, for immediate assistance and posted on a sign no smaller than eight and one-half inches (8½") in width and eleven inches (11") in height.

Postings of (a) and (b) shall be on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height.

(9) "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.

(10) Residents of the facility are exempt from the smoking prohibition. The resident smoking practices shall be governed by the policies and procedures established by the facility. Smoke from such areas shall not infiltrate into areas where smoking is prohibited.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 39-17-1803, 39-17-1804, 39-17-1805, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-213, 68-11-257, 68-11-268, and 71-6-121.* ***Administrative History:*** *Original rule filed June 21, 1997; effective August 6, 1979. Amendment filed August 16, 1988; effective September 30, 1988. Repeal and new rule filed July 27, 2000; effective October 10, 2000. Amendment filed April 20, 2006; effective July 4, 2006. Amendment filed February 23, 2007; effective May 9, 2007. Amendment filed July 18, 2007; effective October 1, 2007. Amendment filed February 22, 2010; effective May 23, 2010. Amendments filed July 18, 2016; effective October 16, 2016. Administrative correction made to URL on September 18, 2018. Emergency rules filed May 29, 2020; effective through November 25, 2020. Emergency rules expired effective November 26, 2020, and the rules reverted to their previous statuses.*

1200-08-11-.05 ADMISSIONS, DISCHARGES AND TRANSFERS.

(1) Only residents whose needs can be met by the facility within its licensure category shall be admitted.

(Rule 1200-08-11-.05, continued)

(2) 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 home for the aged shall disclose in writing to the resident or to the resident's guardian, conservator or representative, if any, whether the facility has liability insurance and the identity of the primary insurance carrier. If the facility is self-insured, their statement shall reflect that fact and indicate the corporate entity responsible for payment of any claims.

(3) The home 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 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 upon admission.

(d) Give a thirty (30) day notice to all residents before any changes in fees can be made.

(e) Ensure that residents see a physician for acute illness or injury and are transferred in accordance with any physician's orders.

(f) The Facility shall document evidence of annual vaccination against influenza for each resident, in accordance with the recommendations 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.

The facility shall 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.

(g) Provide to the resident at the time of admission a copy of the Resident's Rights for the resident's review and signature. A signed copy must be provided to the resident at the time of admission.

(4) Individuals who require professional medical or nursing observation and/or care on a continual or daily basis shall not be admitted to or retained in the home, with the following exception: When an individual who resides in the facility develops a temporary illness, injury, or disability requiring short-term medical or nursing care, the individual may remain in the home if such care can be safely and appropriately given in that setting and is provided by licensed professionals.

(Rule 1200-08-11-.05, continued)

(5) Individuals who are usually, typically or customarily incapable of self-administering medications or who require medications that are usually, typically or customarily not self-administered shall not be admitted to or retained in the home unless provided by a home care organization or physician.

(6) Residents who require professional medical or nursing observation and/or care on a continual or daily basis or who require more technical medical or nursing care than the personnel and the home can lawfully offer on a short-term basis as described in paragraph (3), shall be transferred to a licensed hospital, nursing home or assisted care living facility.

(7) A home for the aged shall not admit or retain residents who pose a clearly documented danger to themselves or to other residents in the home. Persons in the early stages of Alzheimer's Disease and Related Disorders may be admitted only after it has been determined by an interdisciplinary team that care can appropriately and safely be given in the facility. The interdisciplinary team must review such persons at least quarterly as to the appropriateness of placement in the facility. The interdisciplinary team shall consist of, at a minimum, a physician experienced in the treatment of Alzheimer's dDisease and Related Disorders, a social worker, a registered nurse, and a family member (or patient care advocate).

(8) Residents shall be capable of evacuating the home or facility within thirteen (13) minutes. ~~in accordance with Chapter 22 of the Life Safety Code. Residents who cannot evacuate within thirteen (13) minutes shall not be admitted or retained in the facility.~~

(9) The licensee shall not admit or retain a resident who requires physical or chemical restraint.

(10) Facilities utilizing secured units must be able to annually provide survey staff with twelve (12) months of the following performance information specific to the secured unit and its residents:

(a) Documentation that each secured resident has been evaluated by the interdisciplinary team prior to admittance to the unit;

(b) Ongoing and up-to-date documentation of quarterly review by each resident's interdisciplinary team 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 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 and has received annual in-service training which shall include but not be limited to the following subject areas:

(Rule 1200-08-11-.05, continued)

1. Basic facts about the causes, progression and management of Alzheimer's dDisease and related disorders;

2. Dealing with dysfunctional behavior and catastrophic reactions in the residents;

3. Identifying and alleviating safety risks to the residents;

4. Providing assistance in the activities of daily living for the residents; and

5. Communicating with families and other persons interested in the residents.

(11) The facility shall ensure that no person on the grounds of race, color, national origin, or handicap, will be excluded from participation in, be denied benefits of, or otherwise subjected to discrimination in the provision of any care or service of the facility. The facility shall protect the civil rights of residents under the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

(12) Any residential facility licensed by the board of licensing health care facilities shall upon admission provide to each resident the division of adult protective services' statewide toll-free number: 888-277-8366.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-210, 68-11-257, and 71-6-121.* ***Administrative History:*** *Original rule filed June 21, 1979; effective August 6, 1997. Amendment filed August 16, 1988; effective September 30, 1988. Repeal and new rule filed July 27, 2000; effective October 10, 2000. Amendment filed April 20, 2006; effective July 4, 2006. Amendment filed February 23, 2007; effective May 9, 2007.*

1200-08-11-.06 PERSONAL SERVICES.

(1) Personal services must include protective care of the resident, responsibility for the safety of the resident when in the facility, daily awareness of the resident's whereabouts and the ability and readiness to intervene if crises arise. Personal services do not include nursing or medical care. Personal services must be provided by employees of the home.

(2) Medications shall be self-administered. If the home chooses to employ a currently licensed nurse, medications may be administered by the nurse.

(3) Assistance in reading labels, opening bottles, reminding residents of their medication, observing the resident while taking medication and checking the self-administered dose against the dosage shown on the prescription are permissible in the self-administration of medications.

(4) All medications shall be stored so that no resident can obtain another resident's medication.

(5) Residents shall be provided assistance, if needed, in personal care such as bathing, grooming and dressing.

(6) The home for the aged shall provide laundry arrangements for linens for the home and for residents' clothing.

(7) Appropriate storage areas for soiled linen and residents' clothing shall be provided.

(8) Clean linen shall be maintained in sufficient quantity to provide for the needs of the residents. Linens shall be changed whenever necessary.

(Rule 1200-08-11-.06, continued)

(9) There must be a designated person responsible for the food service, including the purchasing of adequate food supplies and the maintenance of sanitary practices in food storage, preparation and distribution. Sufficient arrangements or employees shall be maintained to cook and serve the food.

(10) Residents shall be provided at least three (3) meals per day. The meals shall constitute an acceptable diet. 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). The food must be adapted to the habits, preferences, needs and physical abilities of the residents.

(11) Sufficient food provision capabilities and dining space shall be provided.

(12) A forty-eight (48) hour supply of food shall be maintained and properly stored at all times.

(13) Appropriate equipment and utensils for cooking and serving food shall be provided in sufficient quantity to serve all residents and must be in good repair.

(14) The kitchen shall be maintained in a clean and sanitary condition.

(15) Equipment, utensils and dishes shall be washed after each use.

(16) A suitable and comfortable furnished area shall be provided in the facility for activities and family visits. Furnishings shall include a current calendar and a functioning television set, radio and clock.

(17) The facility shall provide current newspapers, magazines or other reading materials.

(18) The home must have a telephone accessible to all residents to make and receive personal telephone calls twenty-four (24) hours per day.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, and 68-11-204.* ***Administrative History:*** *Original rule filed June 21, 1979; effective August 6, 1979. Amendment filed August 16, 1988; effective September 30, 1988. Repeal and new rule filed July 27, 2000; effective October 10, 2000.*

1200-08-11-.07 BUILDING STANDARDS.

(1) An RHA shall construct, arrange, and maintain the condition of the physical plant and the overall RHA environment in such a manner that the safety and well-being of the patients are assured.

(2) After the applicant has submitted an application and licensure fees, the applicant must submit the building construction plans to the department. All facilities shall conform to the current edition of the following applicable codes as approved by the Board for Licensing Health Care Facilities: International Building Code (excluding Chapters 1 and 11) including referenced International Fuel Gas Code, International Mechanical Code, and International Plumbing Code; National Fire Protection Association (NFPA) NFPA 101 Life Safety Code excluding referenced NFPA 5000; Guidelines for Design and Construction of Health Care Facilities (FGI) including referenced Codes and Standards; U.S. Public Health Service Food Code; and Americans with Disabilities Act (ADA) Standards for Accessible Design. When referring to height, area or construction type, the International Building Code shall prevail. Where there are conflicts between requirements in local codes, the above listed codes, regulations and provisions of this chapter, the most stringent requirements shall apply.

(Rule 1200-08-11-.07, continued)

(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 RHAs, 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 RHAs, including the submission of phased construction plans and the final drawings and the specifications to each.

(5) No new RHA shall be constructed, nor shall major alterations be made to an existing RHA without prior written approval of the department, and unless in accordance with plans and specifications approved in advance by the department. Before any new RHA is licensed or before any alteration or expansion of a licensed RHA 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 where applicable:

(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 where applicable:

(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 where applicable:

(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 where applicable:

(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;

(Rule 1200-08-11-.07, continued)

(c) An electrical system that complies with applicable codes;

(d) Color coding to show all items on emergency power;

(e) Circuit breakers that are properly labeled; and

(f) Ground-Fault Circuit Interrupters (GFCI) that are required in all wet areas, such as kitchens, laundries, janitor closets, bath and toilet rooms, etc, and within six (6) feet of any lavatory.

(14) The electrical drawings shall not include knob and tube wiring, shall not include electrical cords that have splices, and shall not show that the electrical system is overloaded.

(15) In all new facilities or renovations to existing electrical systems, the installation must be approved by an inspector or agency authorized by the State Fire Marshal.

(16) Sprinkler drawings shall include where applicable:

(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.

(17) 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 RHA 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.

(18) It shall be demonstrated through the submission of plans and specifications that in each RHA:

(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 required by the resident;

(Rule 1200-08-11-.07, continued)

(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.

(19) The department shall acknowledge that it has reviewed plans and specifications in writing with copies sent to the project architect, the project engineer, the owner, the manager or other executive of the institution. The department may modify the distribution of such review at its discretion.

(20) In the event submitted materials do not appear to satisfactorily comply with 1200-08-11-.07(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.

(21) The licensed contractor shall execute all construction in accordance with the approved plans and specifications.

(22) 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 1200-08-11-.07(2). 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.

(23) Prior to final inspection, a CD Rom disc, in TIF or PDF format, of the final approved plans including all shop drawings, sprinkler, calculations, hood and duct, addenda, specifications, etc., shall be submitted to the department.

(24) The department requires the following alarms that shall be monitored twenty-four (24) hours per day:

(a) Fire alarms; and

(b) Generators (if applicable).

(25) With the submission of plans the facility shall specify the evacuation capabilities of the patients as defined in the National Fire Protection Code (NFPA). This declaration will determine the design and construction requirements of the facility.

(26) Each RHA shall ensure that an emergency keyed lock box is installed next to each bank of functioning elevators located on the main level. Such lock boxes shall be permanently mounted seventy-two inches (72") from the floor to the center of the box, be operable by a universal key no matter where such box is located, and shall contain only fire service keys and drop keys to the appropriate elevators.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-261.* ***Administrative History:*** *Original rule filed June 21, 1979; effective August 6, 1979. Amendment filed August 16, 1988; effective September 30, 1988. Amendment filed January 30, 1992; effective March 15, 1992. Amendment filed December 7, 1993; effective February 20, 1994. Amendment filed January 6, 1995; effective March 22, 1995. Repeal and new rule filed July 27, 2000; effective October 10, 2000. Amendment filed February 18, 2003; effective May 4, 2003. Amendment filed September 6, 2006; effective November 22, 2006. Amendment filed February 23, 2007; effective May 9, 2007. Repeal and new rule filed December 20, 2011; effective March 19, 2012. Amendment filed January 21, 2016; effective April 20, 2016.*

1200-08-11-.08 LIFE SAFETY.

(1) Any residential home for the aged which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.

(2) The residential home for the aged shall provide fire protection by the elimination of fire hazards, by the installation of necessary fire fighting equipment and by the adoption of a written fire control plan. Fire drills shall be held at least quarterly for each work shift for residential home for the aged personnel in each separate building. There shall be one fire drill per quarter during sleeping hours. There shall be a written report documenting the evaluation of each drill and the action recommended or taken for any deficiencies found. Records which document and evaluate these drills must be maintained for at least three (3) years. All fires which result in a response by the local fire department shall be reported to the department within seven (7) days. The report shall contain sufficient information to ascertain the nature and location of the fire, its probable cause and any injuries incurred by any person or persons as a result of the fire. Initial reports by the facility may omit the name(s) of resident(s) and parties involved, however, should the department find the identities of such persons to be necessary to an investigation, the facility shall provide such information.

(3) Residents who cannot evacuate within thirteen (13) minutes may be retained in the facility so long as such residents are retained in designated areas in accordance with of the Standard Building Code and the National Fire Protection Code (NFPA).

(4) Each resident's room shall have a door that opens directly to the outside or a corridor which leads directly to an exit door and must always be capable of being unlocked by the resident.

(5) Doors to residents' rooms shall not be louvered.

(6) Corridors shall be lighted at all times, to a minimum of one foot candle.

(7) General lighting and night lighting shall be provided for each resident. Night lighting shall be equipped with emergency power.

(8) Corridors and exit doors shall be kept clear of equipment, furniture and other obstacles at all times. There shall be a clear passage at all times from the exit doors to a safe area.

(9) Combustible finishes and furnishings shall not be used.

(10) Open flame and portable space heaters shall not be permitted in the home. Cooking appliances other than microwave ovens shall not be allowed in sleeping rooms.

(11) 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.

(12) Fireplaces and/or fireplace inserts may be used only if provided with guards or screens which are secured in place. Fireplaces and chimneys shall be inspected and cleaned annually and verified documentation shall be maintained.

(13) All electrical equipment shall be maintained in good repair and in safe operating condition.

(14) Electrical cords shall not be run under rugs or carpets.

(15) The electrical systems shall not be overloaded. Power strips must be equipped with circuit breakers. Extension cords shall not be used.

(Rule 1200-08-11-.08, continued)

(16) All facilities must have electrically-operated smoke detectors with battery back-up power operating at all times in, at least, sleeping rooms, day rooms, corridors, laundry room, and any other hazardous areas.

(17) Fire extinguishers, complying with NFPA 10, shall be provided and mounted 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.

(18) Smoking and smoking materials shall be permitted only in designated areas under supervision. Ashtrays must be provided wherever smoking is permitted. Smoking in bed is prohibited. The facility shall have written policies and procedures for smoking within the facility which 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 or activity room.

(19) No smoking signs shall be posted in areas where oxygen is used or stored.

(20) Trash and other combustible waste shall not be allowed to accumulate within and around the home and shall be stored in appropriate containers with tight-fitting lids. Resident rooms shall be furnished with a UL approved trash container.

(21) All safety equipment shall be maintained in good repair and in a safe operating condition.

(22) Janitorial supplies shall not be stored in the kitchen, food storage area, dining area or resident accessible areas.

(23) Flammable liquids shall be stored in approved containers and stored away from the living areas of the facility.

(24) Floor and dryer vents shall be cleaned as frequently as needed to prevent accumulation of lint, soil and dirt.

(25) Emergency telephone numbers must be posted near a telephone accessible to the residents.

(26) The physical environment shall be maintained in a safe, clean and sanitary manner.

(a) Any condition on the facility site conducive to the harboring or breeding of insects, rodents or other vermin shall be prohibited. Chemical substances of a poisonous nature used to control or eliminate vermin shall be properly identified. Such substances shall not be stored with or near food or medications.

(b) The building shall not become overcrowded with a combination of the facility's residents and other occupants.

(c) Each resident bedroom shall contain a chair, bed, mattress, springs, linens, chest of drawers and wardrobe or closet space, either provided by the facility or by the resident if the resident prefers. All furniture provided by the resident must meet NFPA. All resident's clothing must be maintained in good repair and suitable for the use of elderly persons.

(d) The building and its heating, cooling, plumbing and electrical systems shall be maintained in good repair and a clean condition at all times.

(Rule 1200-08-11-.08, continued)

(e) Temperatures in residents' rooms and common areas shall not be less than 65°F and no more than 85°F.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.* ***Administrative History:*** *Original rule filed June 21, 1979; effective August 6, 1979. Amendment filed August 16, 1988; effective September 30, 1988. Amendment filed January 39, 1992; effective March 15, 1992. Repeal and new rule filed July 27, 2000; effective October 10, 2000. Amendment filed September 6, 2006; effective November 6, 2006.*

1200-08-11-.09 INFECTIOUS AND HAZARDOUS WASTE.

(1) Each home for the aged 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 section.

(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 (including but not limited to, 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;

(f) Other waste determined to be infectious by the facility 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 facility.

(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 packages 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 leak_proof, rigid, and puncture-resistant containers which must 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 (including but not limited to, chemical,

(Rule 1200-08-11-.09, continued)

radiologicals) 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 facility must ensure that proper actions are immediately taken to:

(a) Isolate the area from the public and non-essential personnel;

(b) To the extent practicable, repackage all spilled waste and contaminated debris in accordance with the requirements of paragraph 6 of this section;

(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) A facility 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 disinfecting cycle must contain appropriate indicators to assure that conditions were met for proper sterilization or disinfection or 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 v~~i~~olatilized 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

(Rule 1200-08-11-.09, continued)

Conservation, such ash shall be disposable as a (non-hazardous) solid waste under current rules of the Department of Environment and Conservation.

(b) A facility 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) The facility 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 facility 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 facility must notify in writing all public health agencies with jurisdiction that the location is being used for management of the facility'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. §§ 4-5-202 through 4-5-206, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.* ***Administrative History:*** *Original rule filed June 21, 1979; effective August 6, 1979. Repeal and new rule filed July 27, 2000; effective October 10, 2000.*

1200-08-11-.10 RECORDS AND REPORTS.

(1) An individual resident file shall be maintained for each resident in the home. Personal information shall be confidential and shall not be disclosed, except to the resident, the department and others with written authorization from the resident. These files shall be retained for one (1) year after the resident is transferred or discharged. The resident file shall include:

(a) Name, Social Security Number, veteran status and number, marital status, age, sex, previous address and any health insurance provider and number, including Medicare and Medicaid numbers;

(b) Name, address and telephone number of next of kin, legal guardian and any other person identified by the resident to contact on his/her behalf;

(c) Name, address and telephone number of any person or agency providing additional services to the resident;

(d) Date of admission, transfer, discharge and any new forwarding address;

(Rule 1200-08-11-.10, continued)

(e) Name and address of the resident's preferred physician, hospital, pharmacist, assisted care living facility and nursing home, and any other instructions from the resident to be followed in case of emergency;

(f) Record of all monies and other valuables entrusted to the home for safekeeping, with appropriate updates;

(g) Health information including all current prescriptions, major changes in resident's habits or health status, results of physician's visits, and any health care instructions; and

(h) A copy of the admission agreement signed and dated by the resident.

(2) The RHA shall report all incidents of abuse, neglect, and misappropriation to the Department of Health in accordance with T.C.A. § 68-11-211.

(3) The RHA shall report the following incidents to the Department of Health in accordance with T.C.A. § 68-11-211.

(a) Strike by staff at the facility;

(b) External disasters impacting the facility;

(c) Disruption of any service vital to the continued safe operation of the RHA or to the health and safety of its residents and personnel; and

(d) Fires at the RHA that disrupt the provision of resident services or cause harm to the residents or staff, or that are reported by the facility to any entity, including but not limited to a fire department charged with preventing fires.

(4) Legible copies of the following records and reports shall be retained in the facility, shall be maintained in a single file, and shall be made available for inspection during normal business hours for thirty-six (36) months following their issuance. Each resident and each person assuming any financial responsibility for a resident must be fully informed, before admission, of their existence in the home and given the opportunity to inspect the file before entering into any monetary agreement with the facility.

(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; and

(e) Maintenance records of all safety equipment.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, and 68-11-213.* ***Administrative History:*** *Original rule filed June 21, 1979; effective August 6, 1979. Amendment filed February 26, 1985; effective March 28, 1985. Amendment filed August 16, 1988; effective September 30, 1988. Repeal and new rule filed July 27, 2000; effective October 10, 2000. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed December 23, 2009; effective March 23, 2010. Amendments filed January 3, 2012; effective April 2, 2012.*

1200-08-11-.11 RESIDENT RIGHTS. Each resident has at least the following rights:

(1) To privacy in treatment and personal care;

(Rule 1200-08-11-.11, continued)

(2) To be free from mental and physical abuse. Should this right be violated, the facility must notify the department within five (5) working days. The Tennessee Department of Human Services, Adult Protective Services shall be notified immediately as required in T.C.A. § 71-6-103;

(3) To refuse treatment. The resident must be informed of the consequences of that decision, and the refusal and its reason must be reported to the physician and documented in the resident's record;

(4) To have his or her file kept confidential and private. Written consent by the resident must be obtained prior to release of information except to persons authorized by law;

(5) To be fully informed of the Resident's Rights, of any policies and procedures governing resident conduct, any services available in the home and the schedule of all fees for all services;

(6) To participate in drawing up the terms of the admission agreement, including providing for the resident's preferences for physician care, hospitalization, assisted living facility care, nursing home care, acquisition of medication, emergency plans and funeral arrangements;

(7) To be given thirty (30) days written notice prior to transfer or discharge, except when ordered by any physician because a higher level of care is required;

(8) To voice grievances and recommend changes in policies and services of the home with freedom from restraint, interference, coercion, discrimination or reprisal. The resident shall be informed of procedures for registering complaints confidentially and to voice grievances;

(9) 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 home in managing his or her personal financial affairs, the request must be in writing and may be terminated by the resident at any time. The home must separate such monies from the home'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. A current copy of this report shall be maintained in the resident's file maintained by the licensee;

(10) To be treated with consideration, respect and full recognition of his or her dignity and individuality;

(11) To be accorded privacy for sleeping and for storage space for personal belongings;

(12) 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 home, unless such access infringes upon the rights of other residents or unless the resident is admitted to the secured unit;

(13) To wear his or her own clothes, to keep and use his or her own toilet articles and personal possessions;

(14) To send and receive unopened mail;

(15) To associate and communicate privately with persons of his or her choice, including receiving visitors at reasonable hours;

(16) To participate or to refuse to participate in community activities, including cultural, educational, religious, community service, vocational and recreational activities;

(Rule 1200-08-11-.11, continued)

(17) To not be required to perform services for the home. The resident and licensee may mutually agree, in writing, for the resident to perform certain activities or services as part of the fee for his or her stay; and,

(18) To execute, modify, or rescind a Living Will.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.* ***Administrative History:*** *Original rule filed June 21, 1997; effective August 6, 1979. Amendment filed August 16, 1988; effective September 30, 1988. Repeal and new rule filed July 27, 2000; effective October 10, 2000.*

1200-08-11-.12 POLICIES AND PROCEDURES FOR HEALTH CARE DECISION-MAKING.

(1) Pursuant to this Rule, each home for the aged 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 may limit the power of the agent, and may include individual instructions. The effect of an advance directive that makes no limitation on the agent's authority shall be to 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 estate of the resident upon the death of the resident. 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 authority of an agent becomes effective only upon a determination that the resident lacks capacity, and ceases to be effective upon a determination that the resident has recovered capacity.

(5) A facility may use any advanced directive form that meets the requirements of the Tennessee Health Care Decisions Act or has been developed and issued by the Board for Licensing Health Care Facilities.

(6) A determination that a resident lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent shall be made by the designated physician, who is authorized to consult with such other persons as he or she 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.

(Rule 1200-08-11-.12, continued)

(9) A health care facility 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 an 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 an earlier 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 the supervising health care provider. The designation may be oral or written.

(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 resident has been determined by the designated physician to lack capacity, and

2. No agent or guardian has been appointed, or

3. The agent or guardian is not reasonably available.

(c) In the case of a resident who lacks capacity, the resident's surrogate shall be identified by the supervising health care provider and documented in the current clinical record of the facility at which the resident is receiving health care.

(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, be given in order of descending preference for service as a surrogate to:

(Rule 1200-08-11-.12, continued)

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 1200-08-11-.12(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 known wishes of the resident or in accordance with the resident's 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 1200-08-11-.12(16)(c) through 1200-08-11-.12(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,

(Rule 1200-08-11-.12, continued)

the surrogate shall consider the resident's personal values to the extent known to the surrogate.

(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 1200-08-11-.12(16)(m):

1. Neither the treating health care provider nor an employee of the treating health care provider, nor an operator of a health care institution nor an employee of an operator of a health care institution may be designated as a surrogate; 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) An employee of the treating health care provider or an employee of an operator of a health care institution may be designated as a surrogate 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 the 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 1200-08-11-.12(20) through 1200-08-11-.12(22), a health care provider or institution providing care to a resident shall:

(Rule 1200-08-11-.12, continued)

(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 a policy of the institution which is based on reasons of conscience, and

(b) The policy was timely communicated 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 1200-08-11-.12(20) through 1200-08-11-.12(22) shall:

(a) Promptly so inform the resident, if possible, and any person then authorized to make health care decisions for the resident;

(b) Provide continuing care to the resident until a transfer can be effected or until the determination has been made that transfer cannot be effected;

(c) Unless the resident or person then authorized to make health care decisions for the resident refuses assistance, 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; 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

(Rule 1200-08-11-.12, continued)

(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 for such identification 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) Physician Orders for Scope of Treatment (POST)

(a) Physician Orders for Scope of Treatment (POST) may be issued by a physician for a patient with whom the physician has a bona fide physician-patient relationship, but only:

1. With the informed consent of the patient;

2. If the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon 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, if the physician determines that the provision of cardio pulmonary resuscitation would be contrary to accepted medical standards.

(b) A POST may be issued by a physician assistant, nurse practitioner or clinical nurse specialist for a patient with whom such physician assistant, nurse practitioner or clinical nurse specialist has a bona fide physician assistant-patient or nurse-patient relationship, but only if:

1. No physician, who has a bona fide physician-patient relationship with the patient, is present and available for discussion with the patient (or if the patient is a minor or is otherwise incapable of making an informed decision, with the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act);

2. Such authority to issue is contained in the physician assistant's, nurse practitioner's or clinical nurse specialist's protocols;

3. Either:

(i) The patient is a resident of a nursing home licensed under title 68 or an ICF/MR facility licensed under title 33 and is in the process of being discharged from the nursing home or transferred to another facility at the time the POST is being issued; or

(ii) The patient is a hospital patient and is in the process of being discharged from the hospital or transferred to another facility at the time the POST is being issued; and

4. Either:

(i) With the informed consent of the patient;

(ii) If the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon 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

(iii) 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 and such authority to issue is contained in the physician assistant, nurse practitioner or clinical nurse specialist's protocols and the physician assistant or nurse determines that the provision of cardiopulmonary resuscitation would be contrary to accepted medical standards.

(c) If the patient is an adult who is capable of making an informed decision, the patient's expression of the desire to be resuscitated in the event of cardiac or respiratory arrest shall revoke any contrary order in the POST. If the patient is a minor or is otherwise incapable of making an informed decision, the expression of the desire that the patient be resuscitated by the person authorized to consent on the patient's behalf shall revoke any contrary order in the POST. Nothing in this section shall be construed to require cardiopulmonary resuscitation of a patient for whom the physician or physician assistant or nurse practitioner or clinical nurse specialist determines cardiopulmonary resuscitation is not medically appropriate.

(d) A POST issued in accordance with this section shall remain valid and in effect until revoked. In accordance with this rule and applicable regulations, 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, the Department of Mental Health and Substance Abuse Services, or the Department of Intellectual and Developmental Disabilities, or operated, licensed, or owned by another state agency, shall follow a POST that is available to such persons in a form approved by the Board for Licensing Health Care Facilities.

(e) Nothing in these rules shall authorize the withholding of other medical interventions, such as medications, positioning, wound care, oxygen, suction, treatment of airway obstruction or other therapies deemed necessary to provide comfort care or alleviate pain.

(f) If a person has a do-not-resuscitate order in effect at the time of such person's discharge from a health care facility, the facility shall complete a POST prior to discharge. If a person with a POST 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 POST to qualified emergency medical service personnel and to the receiving facility prior to the transfer. The transferring facility shall provide a copy of the POST that accompanies the patient in transport to the receiving health care facility. Upon admission, the receiving facility shall make the POST a part of the patient's record.

(Rule 1200-08-11-.12, continued)

(g) These rules shall not prevent, prohibit, or limit a physician from using a written order, other than a POST, not to resuscitate a patient in the event of cardiac or respiratory arrest in accordance with accepted medical practices. This action shall have no application to any do not resuscitate order that is not a POST, as defined in these rules.

(h) Valid do not resuscitate orders or emergency medical services do not resuscitate orders issued before July 1, 2004, pursuant to then-current law, shall remain valid and shall be given effect as provided in these rules.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-224, and 68-11-1801 through 68-11-1815.* ***Administrative History:*** *Original rule filed June 22, 1992; effective August 6, 1992. Repeal and new rule filed July 27, 2000; effective October 10, 2000. Amendment filed April 28, 2003; effective July 12, 2003. Amendment filed September 8, 2006; effective November 22, 2006. Amendment filed February 7, 2007; effective April 23, 2007. Amendments filed January 3, 2012; effective April 2, 2012. Amendments filed March 27, 2015; effective June 25, 2015,*

1200-08-11-.13 DISASTER PREPAREDNESS.

(1) The administration of every facility shall have in effect and available for all supervisory personnel and staff, written copies of the following required disaster plans for the protection of all persons in the event of fire and other emergencies for evacuation to areas of refuge and/or evacuation from the building. A detailed log with staff signatures of training received shall be maintained. All employees shall be trained annually as required in the following plans and shall be kept informed with respect to their duties under the plans. A copy of the plans and the specific emergency numbers related to that type of disaster shall be readily available at all times. Each of the following plans shall be exercised annually:

(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:

1. Staff duties;

2. Search team, searching the premises;

3. Notification of authorities;

4. Location of suspicious objects; and

(Rule 1200-08-11-.13, continued)

5. Evacuation procedures.

(d) Flood Procedure Plan, if applicable:

1. Staff duties;

2. Evacuation procedures; and

3. Safety procedures following the flood.

(e) Severe Cold Weather and Severe Hot Weather Procedure Plans:

1. Staff duties;

2. Equipment failures;

3. Evacuation procedures; and

4. Emergency food service.

(f) Earthquake Disaster Procedures Plan:

1. Staff duties;

2. Evacuation procedures;

3. Safety procedures; and

4. Emergency services.

(2) All facilities shall participate in the Tennessee Emergency Management Agency local/county emergency plan on an annual basis. Participation includes filling out and submitting a questionnaire on a form to be provided by the Tennessee Emergency Management Agency. Documentation of participation must be maintained and shall be made available to survey staff as proof of participation.

(3) For facilities which elect to have an emergency generator, the generator shall be designed to meet the facility'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 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, and a monthly log shall be maintained by the facility. The facility shall have trained staff familiar with the generator's operation.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Repeal and new rule filed July 27, 2000; effective October 10, 2000.*

1200-08-11-.14 APPENDIX I

(1) Physician Orders for Scope of Treatment (POST) Form

A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

Tennessee Physician Orders for Scope of Treatment (POST, sometimes called "POLST")	Patient's Last Name
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.	First Name/Middle Initial
	Date of Birth

Section A *Check One Box Only*

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **Resuscitate(CPR)** ☐ **Do Not Attempt Resuscitation (DNR / no CPR) (Allow Natural Death)**

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 Only.** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. 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. Treatment Plan: Maximize comfort through symptom management.**

☐ **Limited Additional Interventions.** In addition to care described in Comfort Measures Only above, use medical treatment, antibiotics, IV fluids and cardiac monitoring as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). **Transfer** to hospital if indicated. Generally avoid the intensive care unit. **Treatment Plan: basic medical treatments.**

☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. **Transfer** to hospital and/or intensive care unit if indicated. **Treatment Plan: Full treatment including in the intensive care unit.**

*Other Instructions:*_____

Section C *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION. Oral fluids & nutrition must be offered if feasible.

☐ No artificial nutrition by tube.
☐ Defined trial period of artificial nutrition by tube.
☐ Long-term artificial nutrition by tube.

*Other Instructions:*_____

Section D *Must be Completed*

Discussed with:	**The Basis for These Orders Is:** (Must be completed)
☐ Patient/Resident	☐ Patient's preferences
☐ Health care agent	☐ Patient's best interest (patient lacks capacity or preferences unknown)
☐ Court-appointed guardian	☐ Medical indications
☐ Health care surrogate	☐ (Other) _____
☐ Parent of minor	
☐ Other: _____(Specify)	

Physician/NP/CNS/PA Name (Print)	**Physician/NP/CNS/PA Signature Date**	**MD/NP/CNS/PA Phone Number:**
	NP/CNS/PA (Signature at Discharge)	

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician and/or health care professional. It can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your

preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)	
Agent/Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

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.

To be valid, POST must be signed by a physician or, at discharge or transfer from a hospital or long term care facility, by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Persons with DNR in effect at time of discharge must have POST completed by health care facility prior to discharge and copy of POST provided to qualified medical emergency personnel.

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 Health Care Agent or 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 D and write "VOID" in large letters if POST is replaced or becomes invalid.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

(2) Advance Directive for Health Care Form

ADVANCE DIRECTIVE FOR HEALTH CARE*
(Tennessee)

Instructions: Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

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.

Part I Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____Home Phone: _____Work Phone: _____
Address: _____Mobile Phone: _____Other Phone: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____Home Phone: _____Work Phone: _____
Address: _____Mobile Phone: _____Other Phone: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Part 2 Indicate Your Wishes for Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**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.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

(Rule 1200-08-11-.14, continued)

Indicate Your Wishes for Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ 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 a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Part 3 **Other instructions, such as hospice care, burial arrangements, etc.:** _____

_____

_____

_____

_____

_____

_____

_____

(Attach additional pages if necessary)

Part 4 **Organ donation:** Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

_____

☐ No organ/tissue donation

SIGNATURE

Part 5 Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: _____ Date: _____
(Patient)

_____

Block A Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent or alternate. 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 or alternate. 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

(Rule 1200-08-11-.14, continued)

Block B You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

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: (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1801 through 68-11-815.* ***Administrative History:*** *Original rule filed February 16, 2007; effective May 2, 2007. Repeal and new rule filed August 28, 2012; effective November 26, 2012. Amendment filed March 27, 2015; effective June 25, 2015. Amendments filed February 8, 2017; effective May 9, 2017.*

RULES
OF
TENNESSEE DEPARTMENT OF HEALTH
BOARD FOR LICENSING HEALTH CARE FACILITIES

CHAPTER 1200-08-25
STANDARDS FOR ASSISTED-CARE LIVING FACILITIES

TABLE OF CONTENTS

1200-08-25-.01 PURPOSE.

(1) The purpose of assisted-care living services is to:

(a) Promote the availability of appropriate residential facilities for the elderly and adults with disabilities in the least restrictive and most homelike environment;

(b) Provide assisted-care living services to residents in facilities by meeting each individual's medical and other needs safely and effectively; and

(c) Enhance the individual's ability to age in place while promoting personal individuality, respect, independence, and privacy.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 39-11-106, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-224, and 68-11-1802.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed November 25, 1998; effective February 8, 1999. Amendment filed September 13, 2002; effective November 27, 2002. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed April 28, 2003; effective July 12, 2003. Amendments filed January 24, 2006; effective April 9, 2006. Amendment filed February 7, 2007; effective April 23, 2007. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009.*

1200-08-25-.02 DEFINITIONS.

(1) "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.

(2) "Activities of Daily Living (ADL's)" means those activities which indicate an individual's independence in eating, dressing, personal hygiene, bathing, toileting, ambulating, and medication management.

(3) "Administering Medication" means the direct application of a single dose of medication to the body of a resident by injection, inhalation, ingestion, topical application or by any other means and the placement of a single dose of medication into a container.

(Rule 1200-08-25-.02, continued)

(4) "Administrator" means a natural person designated by the licensee to have the authority and responsibility to manage the ACLF and who is appropriately certified as an assisted-care living facility administrator or is currently licensed in Tennessee as a nursing home administrator as required by T.C.A. §§ 63-16-101, et seq.

(5) "Adult" means a person 18 years of age or older.

(6) "Ambulatory" means the resident's ability to bear weight, pivot and safely walk with the use of a cane, walker, or other mechanical supportive device with or without the minimal assistance of another person. The resident must be physically and mentally capable of self-preservation by evacuating in response to an emergency. A resident who requires a wheelchair must be capable of transferring to and propelling the wheelchair independently.

(7) "Assisted-care living facility (ACLF)" means a building, establishment, complex or distinct part thereof that accepts primarily aged persons for domiciliary care and services.

(8) "Assistance with Self-Administration of Medication" means assistance in reading labels, opening medication containers or packaging, reminding residents of their medication, or observing the resident while taking medication in accordance with the plan of care.

(9) "Assisted-care living facility resident" or "resident" means primarily an aged person who requires domiciliary care, and who upon admission to the facility, if not ambulatory, is capable of self-transfer from the bed to a wheelchair or similar device and is capable of propelling such wheelchair or similar device independently. Such a resident may require one or more of the following services: room and board, assistance with non-medical activities of daily living, administration of typically self-administered medications, and medical services subject to the limitations of these rules.

(10) "Assessment" means a procedure for determining the nature and extent of the problem(s) and needs of a resident or potential resident to ascertain if the ACLF can adequately address those problems, meet those needs, and secure information for the use in the development of the individual care plan.

(11) "Cardiopulmonary resuscitation (CPR)" means the administering of any means or device to restore or support cardiopulmonary functions in a resident, whether by mechanical devices, chest compressions, mouth-to-mouth resuscitation, cardiac massage, tracheal intubation, manual or mechanical ventilators or respirators, defibrillation, the administration of drugs and/or chemical agents intended to restore cardiac and/or respiratory functions in a resident where cardiac or respiratory arrest has occurred or is believed to be imminent.

(12) "Continuous nursing care" means round-the-clock observation, assessment, monitoring, supervision, or provision of nursing services that can only be performed by a licensed nurse.

(13) "Distinct part" means a unit or part thereof that is organized and operated to give a distinct type of care within the larger organization which renders other types or levels of care. "Distinct" denotes both organizational and physical separateness. A distinct part of an ACLF must be physically identifiable and be operated distinguishably from the rest of the institution. It must consist of all the beds within that unit such as a separate building, floor, wing or ward. Several rooms at one end of a hall or one side of a corridor is acceptable as a distinct part of an ACLF.

(14) "Do-Not-Resuscitate Order (DNR)" means a written order, other than a POST, not to resuscitate a patient in cardiac or respiratory arrest in accordance with accepted medical practices.

(Rule 1200-08-25-.02, continued)

(15) "Emergency" means any situation or condition which presents an imminent danger of death or serious physical or mental harm to residents.

(16) "Health care" means any care, treatment, service or procedure to maintain, diagnose, treat, or otherwise affect an individual's physical or mental condition, and includes medical care as defined in T.C.A. § 32-11-103(5).

(17) "Health care decision" means an individual's consent, refusal of consent or withdrawal of consent to health care.

(18) "Health care decision-maker" means that in the case of a resident who lacks capacity, the resident's health care decision-maker is one of the following: the resident's health care agent as specified in an advance directive, the resident's court-appointed guardian or conservator with health care decision-making authority, the resident's surrogate as determined pursuant T.C.A. § 68-11-1806, or the individual's designated physician pursuant to T.C.A. § 68-11-1802(a)(4).

(19) "Infectious waste" means solid or liquid wastes which contain pathogens with sufficient virulence and quantity such that exposure could result in an infectious disease.

(20) "Licensed health care professional" means:

(a) Any health care professional currently licensed by the State of Tennessee to practice within the scope of a regulated profession, such as a nurse practitioner, dietitian, dentist, occupational therapist, pharmacist, physical therapist, physician, physician assistant, psychologist, social worker, speech-language pathologist, and emergency service personnel; or

(b) A medication aide (as defined in Tennessee Code Annotated § 63-7-127).

(21) "Licensee" means the person, association, partnership, corporation, company or public agency to which the license is issued.

(22) "Life threatening or serious injury" means an injury requiring the resident to undergo significant diagnostic or treatment measures.

(23) "Medical record" means documentation of medical histories, nursing and treatment records, care needs summaries, physician orders, and records of treatment and medication ordered and given which must be maintained by the ACLF, regardless of whether such services are rendered by ACLF staff or by arrangement with an outside source.

(24) "Medically inappropriate treatment" means resuscitation efforts that cannot be expected either to restore cardiac or respiratory function to the resident or other medical or surgical treatments that cannot be expected to achieve the expressed goals of the informed resident.

(25) "Medication Aide" means an individual who administers medications, as set forth in Tennessee Code Annotated § 63-7-127, under the general supervision of a licensed nurse pursuant to this section.

(26) "Misappropriation of patient/resident property" means the deliberate misplacement, exploitation or wrongful, temporary or permanent use of an individual's belongings or money without the individual's consent.

(27) "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness; however, the withholding of authorization for or provision of medical care to any terminally ill person who has executed an irrevocable living will in

(Rule 1200-08-25-.02, continued)

accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of the living will, shall not be deemed "neglect" for purposes of these rules.

(28) "NFPA" means the National Fire Protection Association.

(29) "Person" means an individual, association, estate, trust, corporation, partnership, joint venture, government, governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

(30) "Personal services" means those services rendered to residents who need supervision or assistance in activities of daily living. Personal services do not include nursing or medical care.

(31) "Physician Assistant" means a person who has graduated from a physician assistant educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant, has passed the Physician Assistant National Certifying Examination, and is currently licensed in Tennessee as a physician assistant under title 63, chapter 19.

(32) "Physician Orders for Scope of Treatment" or "POST" means written orders that:

(a) Are on a form approved by the Board for Licensing Health Care Facilities;

(b) Apply regardless of the treatment setting and that are signed as required herein by the patient's physician, physician assistant, nurse practitioner, or clinical nurse specialist; and

(c) 1. Specify whether, in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should or should not be attempted;

2. Specify other medical interventions that are to be provided or withheld; or

3. Specify both 1 and 2.

(33) "Power of Attorney for Health Care" means the legal designation of an agent to make health care decisions for the individual granting such power under T.C.A. Title 34, Chapter 6, Part 2.

(34) "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.

(35) "Resident sleeping unit" means a single unit providing sleeping facilities for one or more persons. Resident sleeping units can also include permanent provisions for living, eating and sanitation.

(36) "Responsible attendant" means the individual person designated by the licensee to provide personal services to the residents.

(37) "Secured unit" means a distinct part of an ACLF where the residents are intentionally denied egress except as is necessary to comply with life safety requirements.

(38) "Self-Administration of Medication" means the ability to administer medicine to oneself without assistance other than receiving help with reading labels or with physically opening the container or packaging, being reminded of one's medication, or being observed while taking medication in accordance with the plan of care.

(Rule 1200-08-25-.02, continued)

(39) "Supervising health care provider" means the health care provider who has undertaken primary responsibility for an individual's health care.

(40) "Surrogate" means an individual, other than a resident's agent or guardian, authorized to make a health care decision for the resident pursuant to T.C.A. § 68-11-1806.

(41) "Treating health care provider" means a health care provider directly or indirectly involved in providing health care to a resident at the time such care is needed by the resident.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-210, and 68-11-211.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed November 19, 2003; effective February 2, 2004. Amendment filed January 19, 2007; effective April 4, 2007. Amendment filed February 23, 2007; effective May 9, 2007. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009. Amendment filed January 3, 2012; effective April 2, 2012. Amendment filed March 27 2015; effective June 25, 2015. Amendments filed July 10, 2018; effective October 8, 2018.*

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 shall expire and become invalid annually on the anniversary date of their original issuance.

(a) In order to successfully renew a license, Department inspectors will periodically inspect each ACLF to determine its compliance with these rules and regulations. If the inspectors find deficiencies, the licensee shall submit an acceptable corrective action plan and shall remedy the deficiencies.

(b) If a licensee fails to renew its license prior to the date of its expiration but submits the renewal form and fee within sixty (60) days thereafter, the licensee may renew late by paying, in addition to the renewal fee, a late penalty of one hundred dollars ($100) per

(Rule 1200-08-25-.03, continued)

month for each month or fraction of a month that renewal is late; provided that the late penalty shall not exceed twice the renewal fee.

(c) In the event that a licensee fails to renew its license within the sixty (60) day grace period following the license expiration date, then the licensee shall reapply for a license by submitting the following to the Board office:

1. A completed application for licensure; and

2. The license fee provided in rule 1200-08-25-.04(1).

(d) Upon reapplication, the licensee shall submit to an inspection of the ACLF by Department of Health inspectors.

(5) The Board shall issue a license only for the licensee and the location designated on the license application. If an ACLF moves to a new location, it shall obtain a new license and submit to an inspection of the new building before admitting residents.

(6) A separate license shall be required for each ACLF when more than one facility is operated under the same management or ownership.

(7) Any admission in excess of the licensed bed capacity is prohibited.

(8) Change of Ownership.

(a) A change of ownership occurs whenever the ultimate legal authority for the responsibility of the ACLF's operation is transferred, including a change in the legal structure by which the ACLF is owned and operated, and/or whenever ownership of the preceding or succeeding entity changes.

(b) A licensee shall notify the Board's administrative office of a proposed change of ownership within at least thirty (30) days prior to its occurrence by submitting the following to the Board office:

1. A completed change of ownership application on a form approved by the Board;

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;

(Rule 1200-08-25-.03, continued)

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 twenty-one (21) years of age;

(Rule 1200-08-25-.03, continued)

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. §§ 4-5-202, 4-5-204, 4-5-219, 4-5-312, 4-5-316, 4-5-317, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-208, 68-11-209, 68-11-213, 68-11-216, and Chapter 846 of the Public Acts of 2008, § 1.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed March 1, 2007; effective May 15, 2007. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20,*

(Rule 1200-08-25-.03, continued)
2010. Amendment filed September 24, 2009; effective December 23, 2009. Amendment filed December 16, 2013; effective March 16, 2014. Amendments filed July 10, 2018; effective October 8, 2018.

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	$1,040.00
(b)	25 to 49 beds, inclusive	$1,300.00
(c)	50 to 74 beds, inclusive	$1,560.00
(d)	75 to 99 beds, inclusive	$1,820.00
(e)	100 to 124 beds, inclusive	$2,080.00
(f)	125 to 149 beds, inclusive	$2,340.00
(g)	150 to 174 beds, inclusive	$2,600.00
(h)	175 to 199 beds, inclusive	$2,860.00

For ACLFs of two hundred (200) beds or more, the fee shall be two thousand eight hundred and sixty dollars ($2,860.00) 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. §§ 4-5-202, 4-5-204, 68-3-511, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-216, 68-11-257, and 71-6-121.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed November 25, 1998; effective February 8, 1999. Amendment filed September 21, 2001; effective December 5, 2001. Amendment filed April 20, 2006; effective July 4, 2006. Amendment filed February 23, 2007; effective May 9, 2007. Amendment filed July 18, 2007; effective October 1, 2007. Public necessity rule filed May 13, 2009; through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009. Amendments filed March 26, 2019; effective June 24, 2019.*

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:

(Rule 1200-08-25-.05, continued)

(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. § 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;

(Rule 1200-08-25-.05, continued)

(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 1360-04-01-.18 regarding petitions for reconsiderations and stays in that case.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-213 (i), and 68-11-257.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed November 25, 1998; effective February 8, 1999. Amendment filed February 15, 2000; effective April 30, 2000. Amendment filed September 13, 2002; effective November 27, 2002. Amendment filed May 24, 2004; effective August 7, 2004. Amendment filed April 20, 2006; effective July 4, 2006. Amendment filed February 23, 2007; effective May 9, 2007. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009.*

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~~ twenty-one (21~~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.

The licensee shall also pass the Jurisprudence Examination prior to licensure. The Board Administrative staff shall forward the exam to the licensee. The examination must be completed and returned to the Board Administrative Office (Office of Health Care Facilities) before the expiration of ninety (90) days from the date of notification of eligibility, or the applicant shall forfeit eligibility for licensure and must repeat the licensure process.

The scope, format, and content of the examination shall be determined by the Board Administrative staff but limited to statutes and rules governing practices and facilities.

Correctly answering ninety percent (90%) of the examination questions shall constitute a passing score and successful completion of the jurisprudence exam. Applicants who fail to achieve a passing score on the examination may apply to retake it by written request to the Board Administrative Office and payment of the Jurisprudence Examination Fee.

(Rule 1200-08-25-.06, continued)

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

(Rule 1200-08-25-.06, continued)

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.

(Rule 1200-08-25-.06, continued)

(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 Assisted-Care Living Facility shall have an annual influenza vaccination program which shall include at least:

1. The offer of influenza vaccination to all staff and independent practitioners at no cost to the person or acceptance of documented evidence of vaccination from another vaccine source or facility. The Assisted-Care Living Facility will encourage all staff and independent practitioners to obtain an influenza vaccination;

2. A signed declination statement on record from all who refuse the influenza vaccination for reasons other than medical contraindications (a sample form is available at http://tennessee.gov/health/topic/hcf-provider);

3. Education of all employees about the following:

(i) Flu vaccination;

(ii) Non-vaccine control measures; and

(iii) The diagnosis, transmission, and potential impact of influenza;

4. An annual evaluation of the influenza vaccination program and reasons for non-participation; and

5. A statement that the requirements to complete vaccinations or declination statements shall be suspended by the administrator in the event of a vaccine shortage as declared by the Commissioner or the Commissioner's designee.

(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;

(Rule 1200-08-25-.06, continued)

(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. §§ 4-5-202, 39-17-1804, 39-17-1805, 68-3-511, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-213, 68-11-254, 68-11-268, and 71-6-121.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed January 7, 2000; effective March 22, 2000. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009. Amendment filed March 27, 2015; effective June 25, 2015. Amendments filed July 18, 2016; effective October 16, 2016. Emergency rules filed May 29, 2020; effective through November 25, 2020. Emergency rules expired effective November 26, 2020, and the rules reverted to their previous statuses.*

1200-08-25-.07 SERVICES PROVIDED.

(1) An ACLF may provide medical services as follows:

(a) Administer medications to residents that are typically self-administered as subject to limitations described within these rules and regulations.

(b) All other medical services prescribed by the physician that could be provided to a private citizen in the citizen's home, including, but not limited to:

1. Part-time or intermittent nursing care;

2. Various therapies;

3. Podiatry care;

4. Medical social services;

5. Medical supplies;

6. Durable medical equipment; and

7. Hospice services.

(c) Intravenous medications may only be administered to:

1. Existing residents who receive them on an intermittent basis; and

2. Residents receiving hospice care.

(2) Medical services in an ACLF shall be provided by:

(Rule 1200-08-25-.07, continued)

(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 or certified health care professional operating within the scope of the professional license or certification and according to the resident's plan of care.

(c) Ensure that during the course of administering medication, a medication aide shall not be assigned any other non-medication administration duties. However, a medication aide shall not be precluded from responding, as appropriate, to an emergency;

(d) Store all medications via a locked or closed container and/or room which includes, but is not limited to, some type of box, piece of furniture, an individual resident room, and/or a designated room within the facility which maintains resident medication out of the sight of other residents; and

(e) Ensure that facility staff shall not repackage medication and shall not administer medication from repackaging.

(6) An ACLF shall dispose of medications as follows:

(a) Upon discharge of a resident, unused prescription medication shall be released to the resident, the resident's family member, or the resident's legal representative, unless specifically prohibited by the attending physician.

(b) Upon death of a resident, unused prescription medication must be destroyed in the manner outlined, and by the individuals designated, in the facility's medication disposal policy, unless otherwise requested by the resident's family member or the resident's legal representative and accompanied by a written order by a physician. The ACLF's medication disposal policy shall be written in accordance with current FDA or current DEA medication disposal guidelines;

(c) The ACLF shall properly dispose of prescription medication administered by the facility in accordance with the facility's medication disposal policy, which shall be written in accordance with current FDA or current DEA medication disposal guidelines.

(Rule 1200-08-25-.07, continued)

(d) The ACLF may dispose of prescription medication that is self-administered by the resident according to the facility's medication disposal policy, which shall be written in accordance with current FDA or current DEA medication disposal guidelines, or the facility may provide information to the resident's family member or the resident's legal representative regarding the proper method to dispose of the medication.

(e) If the resident is a hospice patient, hospice shall be responsible for disposing of the prescription medication upon the death of the resident.

(f) The ACLF's medication disposal policy shall be performed by a licensed or certified health care professional and either the facility's administrator, or a second licensed or certified health care professional.

(g) The ACLF's medication disposal policy shall also address the disposal of scheduled drugs, non-scheduled drugs, and devices that are misbranded, expired, deteriorated, not kept under proper conditions, and kept in containers with illegible or missing labels.

(7) An ACLF shall provide personal services as follows:

(a) Each ACLF shall provide each resident with at least the following personal services:

1. Protective care;

2. Safety when in the ACLF;

3. Daily awareness of the individual's whereabouts;

4. The ability and readiness to intervene if crises arise;

5. Room and board; and

6. Non-medical living assistance with activities of daily living.

(b) Laundry services. An ACLF shall:

1. Provide arrangements for laundry of ACLF linens and residents' clothing;

2. Provide appropriate separate storage areas for soiled linens and residents' clothing; and

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. §§ 4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-261.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998.*

(Rule 1200-08-25-.07, continued)

Amendment filed November 25, 1999; effective February 8, 1999. Amendment filed August 26, 2002; effective November 9, 2002. Amendment filed February 18, 2003; effective May 4, 2003. Repeal and new rule filed January 24, 2006; effective April 9, 2006. Amendment filed February 23, 2007; effective May 9, 2007. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009. Amendment filed March 27, 2015; effective June 25, 2015. Amendments filed July 10, 2018; effective October 8, 2018.

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;

(Rule 1200-08-25-.08, continued)

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;

(Rule 1200-08-25-.08, continued)

(g) Have written policies and procedures to assist residents in the proper development, filing, modification and rescission of an advance directive, a living will, a do-not-resuscitate order, and the appointment of a durable power of attorney for health care;

(h) Prior to the admission of a resident or prior to the execution of a contract for the care of a resident (whichever occurs first), each ACLF shall disclose in writing to the resident or to the resident's legal representative, whether the ACLF has liability insurance and the identity of the primary insurance carrier. If the ACLF is self-insured, its statement shall reflect that fact and indicate the corporate entity responsible for payment of any claims;

(i) Document evidence of annual vaccination against influenza for each resident, in accordance with the recommendation of the Advisory Committee on Immunization Practices of the Centers for Disease Control most recent to the time of vaccine, unless such vaccination is medically contraindicated or the resident has refused the vaccine. Influenza vaccination for all residents accepting the vaccine shall be completed by November 30 of each year or within ten (10) days of the vaccine becoming available. Residents admitted after this date during the flu season and up to February 1, shall as medically appropriate, receive influenza vaccination prior to or on admission unless refused by the resident; and

(j) Document evidence of vaccination against pneumococcal disease for all residents who are sixty-five (65) years of age or older, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control at the time of vaccination, unless such vaccination is medically contraindicated or the resident has refused offer of the vaccine. The facility shall provide or arrange the pneumococcal vaccination of residents who have not received this immunization prior to or on admission unless the resident refuses offer of the vaccine.

(k) Prior to the admission of a resident or prior to the execution of a contract for the care of a resident (whichever occurs first), each ACLF shall disclose in writing to the resident or to the resident's legal representative a copy of the medication disposal policy, which shall be written in accordance with current FDA or current DEA medication disposal guidelines.

(7) An ACLF shall have documented plans and procedures to show evacuation of all residents.

(8) ~~An ACLF may not retain a resident who cannot evacuate within thirteen (13) minutes unless the ACLF complies with Chapter 19 of the 2006 edition of the NFPA Life Safety Code, and the Institutional Unrestrained Occupancy of the 2006 edition of the International Building Code.~~Residents shall be capable of evacuating the home or facility within thirteen (13) minutes.

(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 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;

(Rule 1200-08-25-.08, continued)

(c) A current listing of the number of deaths and hospitalizations, with diagnoses~~,~~ that have occurred on the unit;

(d) A current listing of all unusual incidents and/or complications on the unit;

(e) An up-to-date staffing pattern and staff ratios for the unit that is recorded on a daily basis. The staffing pattern must ensure that there is a minimum of one (1) attendant, awake, on duty, and physically located on the unit twenty-four (24) hours per day, seven (7) days per week, at all times;

(f) A formulated calendar of daily group activities scheduled, including a resident attendance record for the previous three (3) months;

(g) An up-to-date listing of any incidences of decubitus and/or nosocomial infections, including resident identifiers; and

(h) Documentation showing that 100% of the staff working on the unit receives annual in-service training which shall include, but not be limited to, the following subject areas:

1. Basic facts about the causes, progression and management of Alzheimer's disease and related disorders;

2. Dealing with dysfunctional behavior and catastrophic reactions in the residents;

3. Identifying and alleviating safety risks to the resident;

4. Providing assistance in the activities of daily living for the resident; and

5. Communicating with families and other persons interested in the resident.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-201(5), 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-211, 68-11-263, and 68-11-266.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed January 7, 2000; effective March 22, 2000. Amendment filed February 18, 2003; effective May 4, 2003. Repeal and new rule filed January 24, 2006; effective April 9, 2006. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009. Amendment filed March 27, 2015; effective June 25, 2015. Amendments filed July 10, 2018; effective October 8, 2018.*

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 facilities shall conform to the current edition of the following applicable codes as approved by the Board for Licensing Health Care Facilities: International Building Code (excluding Chapters 1 and 11) including referenced International Fuel Gas Code, International Mechanical Code, and International Plumbing Code; National Fire Protection Association (NFPA) NFPA 101 Life Safety Code excluding referenced NFPA 5000; Guidelines for Design and Construction of Health Care Facilities (FGI) including referenced Codes and Standards; U.S. Public Health Service Food Code; and Americans with Disabilities Act (ADA) Standards for Accessible Design. When referring to height, area or construction type, the International Building Code shall prevail. Where there

(Rule 1200-08-25-.09, continued)

are conflicts between requirements in local codes, the above listed codes, regulations and provisions of this chapter, the most stringent requirements shall apply.

(3) The codes in effect at the time of submittal of plans and specifications, as defined by these rules, shall be the codes to be used throughout the project.

(4) 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;

(Rule 1200-08-25-.09, continued)

(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 where applicable:

(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;

(Rule 1200-08-25-.09, continued)

(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) An electrical system that complies with applicable codes;

(d) Color coding to show all items on emergency power;

(e) Circuit breakers that are properly labeled; and

(f) Ground-Fault Circuit Interrupters (GFCI) that are required in all wet areas, such as kitchens, laundries, janitor closets, bath and toilet rooms, etc., and within six (6) feet of any lavatory.

(14) The electrical drawings shall not include knob and tube wiring, shall not include electrical cords that have splices, and shall not show that the electrical system is overloaded.

(15) In all new facilities or renovations to existing electrical systems, the installation must be approved by an inspector or agency authorized by the State Fire Marshal.

(16) 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.

(17) 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.

(18) 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;

(Rule 1200-08-25-.09, continued)

(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.

(19) 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.

(20) 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.

(21) 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.

(22) The licensed contractor shall execute all construction in accordance with the approved plans and specifications.

(23) 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.

(24) Prior to final inspection, a CD Rom disc, in TIF or PDF format, of the final approved plans including all shop drawings, sprinkler, calculations, hood and duct, addenda, specifications, etc., shall be submitted to the department.

(25) The department requires the following alarms that shall be monitored twenty-four (24) hours per day:

(a) Fire alarms; and

(b) Generators (if applicable).

(26) Each ACLF shall ensure that an emergency keyed lock box is installed next to each bank of functioning elevators located on the main level. Such lock boxes shall be permanently mounted seventy-two inches (72") from the floor to the center of the box, be operable by a universal key no matter where such box is located, and shall contain only fire service keys and drop keys to the appropriate elevators.

Authority: *T.C.A. §§ 4-5-202, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-261.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009. Amendments filed December 20, 2011; effective March 19, 2012. Amendment filed January 21, 2016; effective April 20, 2016.*

(Rule 1200-08-25-.09, continued)

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) Ensure that upon entering the ACLF, the resident or his or her responsible party is asked if they wish to have a cooking appliance that is appropriate for their level of cognition. If the facility chooses to provide a requested cooking appliance, it shall be used in accordance with the facility's policies. If the resident or his or her responsible party wishes to provide their own cooking appliance, it shall meet the facility's policies and safety standards. The cooking appliances shall be designed so that they can be disconnected and removed for resident safety or if the resident chooses not to have cooking capability within his or her apartment. The cooking appliances shall have an automatic timer;

(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 and maintain travel distance between fire extinguishers, complying with NFPA 10, so they are accessible to all residents in the kitchen, laundries and at all exits.

(Rule 1200-08-25-.10, continued)

(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;

(Rule 1200-08-25-.10, continued)

(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.

(Rule 1200-08-25-.10, continued)

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, and 68-11-213.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed April 11, 2003; effective June 25, 2003. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009. Amendments filed July 10, 2018; effective October 8, 2018.*

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.

(Rule 1200-08-25-.11, continued)

(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.

(Rule 1200-08-25-.11, continued)

(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. §§ 4-5-202, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009.*

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;

(Rule 1200-08-25-.12, continued)

(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

(Rule 1200-08-25-.12, continued)

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. §§ 4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-224, and 68-11-1801 through 68-11-1815.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Amendment filed April 28, 2003; effective July 12, 2003. Repeal and new rule filed January 24, 2006; effective April 9, 2006. Amendment filed February 7, 2007; effective April 23, 2007. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009.*

1200-08-25-.13 REPORTS.

(1) The ACLF shall report all incidents of abuse, neglect, and misappropriation to the Department of Health in accordance with T.C.A. § 68-11-211.

(Rule 1200-08-25-.14, continued)

(2) The ACLF shall report the following incidents to the Department of Health in accordance with T.C.A. § 68-11-211.

(a) Strike by staff at the facility;

(b) External disasters impacting the facility;

(c) Disruption of any service vital to the continued safe operation of the ACLF or to the health and safety of its patients and personnel; and

(d) Fires at the ACLF that disrupt the provision of patient care services or cause harm to the patients or staff, or that are reported by the facility to any entity, including but not limited to a fire department charged with preventing fires.

(3) 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. §§ 4-5-202, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-211.* ***Administrative History:*** *Original rule filed February 9, 1998; effective April 25, 1998. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009. Amendments filed January 3, 2012; effective April 2, 2012.*

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

(Rule 1200-08-25-.14, continued)

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. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.* ***Administrative History:*** *Original rule filed February 16, 2007; effective May 2, 2007. Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009.*

1200-08-25-.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

(Rule 1200-08-25-.15, continued)

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.

(Rule 1200-08-25-.15, continued)

(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;

(Rule 1200-08-25-.15, continued)

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) through 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:

(Rule 1200-08-25-.15, continued)

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) through 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.

(Rule 1200-08-25-.15, continued)

(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) through 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) Physician Orders for Scope of Treatment (POST)

(a) Physician Orders for Scope of Treatment (POST) may be issued by a physician for a patient with whom the physician has a bona fide physician-patient relationship, but only:

1. With the informed consent of the patient;

(Rule 1200-08-25-.15, continued)

2. If the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon 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, if the physician determines that the provision of cardio pulmonary resuscitation would be contrary to accepted medical standards.

(b) A POST may be issued by a physician assistant, nurse practitioner or clinical nurse specialist for a patient with whom such physician assistant, nurse practitioner or clinical nurse specialist has a bona fide physician assistant-patient or nurse-patient relationship, but only if:

1. No physician, who has a bona fide physician-patient relationship with the patient, is present and available for discussion with the patient (or if the patient is a minor or is otherwise incapable of making an informed decision, with the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act);

2. Such authority to issue is contained in the physician assistant's, nurse practitioner's or clinical nurse specialist's protocols;

3. Either:

(i) The patient is a resident of a nursing home licensed under title 68 or an ICF/MR facility licensed under title 33 and is in the process of being discharged from the nursing home or transferred to another facility at the time the POST is being issued; or

(ii) The patient is a hospital patient and is in the process of being discharged from the hospital or transferred to another facility at the time the POST is being issued; and

4. Either:

(i) With the informed consent of the patient;

(ii) If the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon 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

(iii) 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 and such authority to issue is contained in the physician assistant, nurse practitioner or clinical nurse specialist's protocols and the physician assistant or nurse determines that the provision of cardiopulmonary resuscitation would be contrary to accepted medical standards.

(Rule 1200-08-25-.15, continued)

(c) If the patient is an adult who is capable of making an informed decision, the patient's expression of the desire to be resuscitated in the event of cardiac or respiratory arrest shall revoke any contrary order in the POST. If the patient is a minor or is otherwise incapable of making an informed decision, the expression of the desire that the patient be resuscitated by the person authorized to consent on the patient's behalf shall revoke any contrary order in the POST. Nothing in this section shall be construed to require cardiopulmonary resuscitation of a patient for whom the physician or physician assistant or nurse practitioner or clinical nurse specialist determines cardiopulmonary resuscitation is not medically appropriate.

(d) A POST issued in accordance with this section shall remain valid and in effect until revoked. In accordance with this rule and applicable regulations, 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, the Department of Mental Health and Substance Abuse Services, or the Department of Intellectual and Developmental Disabilities, or operated, licensed, or owned by another state agency, shall follow a POST that is available to such persons in a form approved by the Board for Licensing Health Care Facilities.

(e) Nothing in these rules shall authorize the withholding of other medical interventions, such as medications, positioning, wound care, oxygen, suction, treatment of airway obstruction or other therapies deemed necessary to provide comfort care or alleviate pain.

(f) If a person has a do-not-resuscitate order in effect at the time of such person's discharge from a health care facility, the facility shall complete a POST prior to discharge. If a person with a POST 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 POST to qualified emergency medical service personnel and to the receiving facility prior to the transfer. The transferring facility shall provide a copy of the POST that accompanies the patient in transport to the receiving health care facility. Upon admission, the receiving facility shall make the POST a part of the patient's record.

(g) These rules shall not prevent, prohibit, or limit a physician from using a written order, other than a POST, not to resuscitate a patient in the event of cardiac or respiratory arrest in accordance with accepted medical practices. This action shall have no application to any do not resuscitate order that is not a POST, as defined in these rules.

(h) Valid do not resuscitate orders or emergency medical services do not resuscitate orders issued before July 1, 2004, pursuant to then-current law, shall remain valid and shall be given effect as provided in these rules.

Authority: *T.C.A. §§ 68-11-209, 68-11-224, and 68-11-1801, et seq.* ***Administrative History:*** *Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009. Amendment filed March 27, 2015; effective June 25, 2015.*

1200-08-25-.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:

(Rule 1200-08-25-.16, continued)

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.

(Rule 1200-08-25-.16, continued)

(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.* ***Administrative History:*** *Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009.*

1200-08-25-.17 APPENDIX I.

(1) Physician Orders for Scope of Treatment (POST) Form

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Tennessee Physician Orders for Scope of Treatment (POST, sometimes called "POLST") 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 is not breathing.** ☐ **Resuscitate(CPR)** ☐ **Do Not Attempt Resuscitation (DNR / no CPR) (Allow Natural Death)** 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 Only.** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. 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. Treatment Plan: Maximize comfort through symptom management.** ☐ **Limited Additional Interventions.** In addition to care described in Comfort Measures Only above, use medical treatment, antibiotics, IV fluids and cardiac monitoring as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). **Transfer** to hospital if indicated. Generally avoid the intensive care unit. **Treatment Plan: basic medical treatments.** ☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. **Transfer** to hospital and/or intensive care unit if indicated. **Treatment Plan: Full treatment including in the intensive care unit.** *Other Instructions:*_____
Section C *Check One*	**ARTIFICIALLY ADMINISTERED NUTRITION. Oral fluids & nutrition must be offered if feasible.** ☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube. ☐ Long-term artificial nutrition by tube. *Other Instructions:*_____

Section D *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/NP/CNS/PA Name (Print)	**Physician/NP/CNS/PA Signature Date** NP/CNS/PA (Signature at Discharge)	**MD/NP/CNS/PA Phone Number:**

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician and/or health care professional. It can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)

(Rule 1200-08-25-.17, continued)

Agent/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.

To be valid, POST must be signed by a physician or, at discharge or transfer from a hospital or long term care facility, by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Persons with DNR in effect at time of discharge must have POST completed by health care facility prior to discharge and copy of POST provided to qualified medical emergency personnel.

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 Health Care Agent or 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 D and write “VOID” in large letters if POST is replaced or becomes invalid.

(Rule 1200-08-25-.17, continued)

(2) Advance Directive for Health Care Form

ADVANCE DIRECTIVE FOR HEALTH CARE*
(Tennessee)

Instructions: Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

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.

Part I Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____Home Phone: _____Work Phone: _
Address: _____Mobile Phone: _____Other Phone: _

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____Home Phone: _____Work Phone: _
Address: _____Mobile Phone: _____Other Phone: _

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Part 2 Indicate Your Wishes for Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**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.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Indicate Your Wishes for Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

(Rule 1200-08-25-.17, continued)

☐ 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 a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Part 3 **Other instructions, such as hospice care, burial arrangements, etc.:** _____

_____

_____

_____

_____

_____

_____

_____

(Attach additional pages if necessary)

Part 4 **Organ donation:** Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

_____

☐ No organ/tissue donation

SIGNATURE

Part 5 Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: _____ Date: _____
(Patient)

_____

Block A Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent or alternate. 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 or alternate. 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

_____

Block B You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE
COUNTY OF _____

(Rule 1200-08-25-.17, continued)

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: (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.* ***Administrative History:*** *Public necessity rule filed May 13, 2009; effective through October 25, 2009. Emergency rule filed October 22, 2009; effective through April 20, 2010. Amendment filed September 24, 2009; effective December 23, 2009. Repeal and new rule filed August 28, 2012; effective November 26, 2012. Amendment filed March 27, 2015; effective June 25, 2015. Amendments filed February 8, 2017; effective May 9, 2017.*