10A NCAC 13B .3801 is readopted with changes as published in 36:12 NCR 1029-1032 as follows:

SECTION .3800 - NURSING SERVICES

10A NCAC 13B .3801 NURSE EXECUTIVE

(a) Whether the facility utilizes a centralized or decentralized organizational structure, a nurse executive shall be responsible for the coordination of nursing organizational functions.

(b) A nurse executive shall develop facility wide patient care programs, ~~policies~~ policies, and procedures that describe how the nursing care needs of patients are assessed, ~~met~~ met, and evaluated.

(c) The nurse executive shall develop and adopt, subject to the approval of the facility, a set of administrative policies and procedures to establish a framework to accomplish required ~~functions.~~ functions as required in Paragraph (e) of this Rule.

(d) There shall be scheduled ~~meetings,~~ meetings ~~at least~~ every 60 ~~days,~~ days of the members of the nursing staff to evaluate the quality and efficiency of nursing services. Minutes of these meetings shall be maintained.

(e) The nurse executive shall be responsible for:

(1) the development of a written organizational plan which describes the levels of accountability and responsibility within the nursing organization;

~~(2) identification of standards and policies and procedures related to the delivery of nursing care;~~

~~(3)~~(2) planning for and the evaluation of the delivery of nursing care ~~delivery~~ system;

~~(4)~~(3) establishment of a mechanism to validate qualifications, knowledge, and skills of nursing personnel;

~~(5)~~(4) provision of orientation and educational opportunities related to expected nursing ~~performance,~~ performance and maintenance of records pertaining thereto;

~~(6)~~(5) implementation of a system for performance evaluation;

~~(7)~~(6) provision of nursing care services in conformance with ~~the North Carolina Nursing Practice Act;~~ G.S. 90-171.20(7) and G.S. 90-171.20(8);

~~(8)~~(7) assignment of nursing staff to clinical or managerial responsibilities based upon educational preparation, in conformance with licensing laws and an assessment of current competence; and

~~(9)~~(8) staffing nursing units with ~~sufficient~~ personnel in accordance with a written ~~plan.~~ plan of care to meet the needs of the patients.

History Note: *Authority G.S. [~~131E-75(b);~~] ~~131E-79;~~ 143B-165;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. August 1, 2023.

10A NCAC 13B .3903 is readopted with changes as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .3903 PRESERVATION OF MEDICAL RECORDS

(a) The manager of the medical records service shall maintain medical ~~records,~~ records that were created when the patient was an adult, whether original, computer media, or ~~microfilm,~~ digital archived for ~~a minimum of~~ 11 years following the discharge of an adult patient.

(b) The manager of medical records shall maintain medical records ~~of a patient who is a minor until the patient's 30th birthday.~~ that were created when the patient was a minor, whether original, computer media, or digital archived, until the patient's 30th birthday. If a minor patient is readmitted as an adult, the manager of the medical records shall maintain medical records according to Paragraph (a) of this Rule.

(c) If a hospital discontinues operation, its management shall make known to the Division where its records are stored. Records shall be stored in a business offering retrieval services for ~~at least~~ 11 years after the closure ~~date.~~ date or according to Paragraph (b) of this Rule if the patient was a minor.

~~(d) The hospital shall give public notice prior to destruction of its records, to permit former patients or representatives of former patients to claim the record of the former patient. Public notice shall be in at least two forms: written notice to the former patient or their representative and display of an advertisement in a newspaper of general circulation in the area of the facility.~~

~~(e)~~(d) The manager of medical records may authorize the ~~microfilming~~ digital archiving of medical records. ~~Microfilming~~ Digital archiving may be done on or off the premises. If done off the premises, the facility shall provide for the confidentiality and safekeeping of the records. The original of ~~microfilmed~~ digital archived medical records shall not be destroyed until the medical records department has had an opportunity to review the ~~processed film~~ digital record for content.

~~(f)~~(e) Nothing in this Section shall be construed to prohibit the use of automation in the medical records service, provided that all of the provisions in this Rule are met and the information is readily available for use in patient care.

~~(g)~~(f) Only personnel authorized by ~~state~~ State laws and the Health Insurance Portability and Accountability Act (HIPAA) ~~regulations~~ found in 42 CFR 482, which is incorporated by reference including subsequent amendments and editions, shall have access to medical records. This regulation may be obtained free of charge at https://www.govinfo.gov/help/cfr. Where the written authorization of a patient is required for the release or disclosure of health information, the written authorization of the patient or authorized representative shall be maintained in the original record as authority for the release or disclosure.

~~(h)~~(g) Medical records are the property of the hospital, and ~~they shall not be removed from the facility jurisdiction~~ shall remain the property of the hospital, except through a court order. Copies shall be made available for authorized purposes such as insurance claims and physician review.

History Note: *Authority G.S. ~~90-21.20B;~~ [~~131E-75(b);~~] ~~131E-79;~~ 131E-97; 143B-165;*
Eff. January 1, 1996;
Amended Eff. July 1, ~~2009.~~ 2009;

Readopted Eff. August 1, 2023.

10A NCAC 13B .4103 is readopted with changes as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .4103 PROVISION OF EMERGENCY SERVICES

(a) Any ~~of any~~ facility providing emergency services shall establish and maintain policies requiring ~~appropriate~~ medical screening, treatment and transfer services for any individual who presents to the facility emergency department and on whose behalf treatment is requested regardless of that person's ability to pay for medical services and without delay to inquire about the individual's method of payment.

(b) Any facility providing emergency services under the rules of this Section shall install, ~~operate~~ operate, and maintain, on a 24-hour per day basis, an emergency two-way radio ~~licensed by the Federal Communications Commission in the Public Safety Radio Service~~ capable of ~~establishing~~ accessing the North Carolina Voice Interoperability Plan for Emergency Responders (VIPER) radio network for voice ~~radio~~ communication with ~~ambulance units~~ EMS providers transporting patients to ~~said~~ the facility or ~~having any written procedure or agreement for handling emergency services with the local ambulance service, rescue squad or other trained medical~~ [~~or~~] provide on-line medical direction for EMS personnel.

(c) All communication equipment shall be in compliance with ~~current~~ the rules ~~established by North Carolina Rules for Basic Life Support/Ambulance Service (10 NCAC 3D .1100) adopted by reference with all subsequent amendments. Referenced rules are available at no charge from the Office of Emergency Medical Services, 2707 Mail Service Center, Raleigh, N.C. 27699-2707.~~ set forth in 10A NCAC 13P, Emergency Medical Services and Trauma Rules.

History Note: *Authority G.S. [~~131E-75(b);~~] ~~131E-79;~~ 143B-165;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. August 1, 2023.

10A NCAC 13B .4104 is readopted with changes as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .4104 MEDICAL DIRECTOR

(a) The governing body shall establish the qualifications, duties, and authority of the director of emergency services. Appointments shall be recommended by the medical staff and approved by the governing body.

(b) The medical staff credentials committee shall approve the mechanism for emergency privileges for physicians employed for brief periods of time such as evenings, ~~weekends~~ weekends, or holidays.

(c) Level I and II emergency services shall be directed and supervised by a ~~physician with experience in emergency care.~~ physician.

(d) Level III services shall be directed and supervised by a ~~physician with experience in emergency care or through a multi-disciplinary medical staff committee. The chairman of this committee shall serve as director of emergency medical services.~~ physician.

History Note: *Authority G.S. [~~131E-75(b);~~] ~~131E-79;~~ 131E-85(a); 143B-165;*
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. August 1, 2023.

10A NCAC 13B .4106 is readopted with changes as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .4106 POLICIES AND PROCEDURES

Each emergency department shall establish written policies and procedures ~~which~~ that specify the scope and conduct of patient care to be provided in the emergency areas. They shall include the following:

(1) the location, storage, and procurement of medications, blood, supplies, ~~equipment~~ equipment, and the procedures to be followed in the event of equipment failure;

(2) the initial management of patients with burns, hand injuries, head injuries, fractures, multiple injuries, poisoning, animal bites, gunshot or stab ~~wounds~~ wounds, and other acute problems;

(3) the provision of care to an unemancipated minor not accompanied by a parent or guardian, or to an unaccompanied unconscious patient;

(4) management of alleged or suspected child, ~~elder~~ elder, or adult abuse;

(5) the management of pediatric emergencies;

(6) the initial management of patients with actual or suspected exposure to radiation;

(7) management of alleged or suspected rape victims;

(8) the reporting of individuals dead on arrival to the proper authorities;

(9) the use of standing orders;

(10) tetanus and rabies prevention or prophylaxis; and

(11) the dispensing of medications in accordance with ~~state~~ State and federal laws.

History Note: *Authority G.S. [~~131E-75(b);~~] ~~131E-79;~~ 143B-165;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. August 1, 2023.

10A NCAC 13B .4305 is readopted with changes as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .4305 ORGANIZATION OF NEONATAL SERVICES

(a) The governing body shall approve the scope of all neonatal services and the facility shall classify its capability in providing a range of neonatal services using the following criteria:

(1) LEVEL I: Full-term and pre-term neonates that are stable without complications. This may ~~include,~~ include infants who are small for gestational age or neonates who are large for gestational ~~age neonates.~~ age.

(2) LEVEL II: Neonates or infants that are stable without complications but require special care and frequent feedings; infants of any weight who no longer require ~~Level~~ LEVEL III or LEVEL IV neonatal services, but who still require more nursing hours than normal infant. This may include infants who require close observation in a licensed acute care ~~bed~~ bed.

(3) LEVEL III: Neonates or infants that are high-risk, small ~~(or~~ or approximately 32 and less than 36 completed weeks of gestational ~~age)~~ age but otherwise healthy, or sick with a moderate degree of illness that are admitted from within the hospital or transferred from another facility requiring intermediate care services for sick infants, but not requiring intensive care. The beds in this level may serve as a "step-down" unit from Level IV. Level III neonates or infants require less constant nursing care, but care does not exclude respiratory support.

(4) LEVEL IV (Neonatal Intensive Care Services): High-risk, medically ~~unstable~~ unstable, or critically ill neonates ~~approximately~~ under 32 weeks of gestational age, or infants, requiring constant nursing care or supervision ~~not limited to~~ that includes continuous cardiopulmonary or respiratory support, complicated surgical procedures, or other intensive supportive interventions.

(b) The facility shall provide for the availability of equipment, supplies, and clinical support services.

(c) The medical and nursing staff shall develop and approve policies and procedures for the provision of all neonatal services.

History Note: *Authority G.S. [~~131E-75(b);~~] ~~131E-79;~~ 143B-165;*
Eff. January 1, 1996;
Temporary Amendment Eff. March 15, 2002;
Amended Eff. April 1, ~~2003.~~ 2003;
Readopted Eff. August 1, 2023.

10A NCAC 13B .4603 is readopted with changes as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .4603 SURGICAL AND ANESTHESIA STAFF

~~(a)~~ The facility shall develop processes ~~which require that~~ that require each individual ~~provides~~ provide only those services for which proof of licensure and competency can be demonstrated. The facility shall require that:

~~(b) The facility shall require that:~~

(1) when anesthesia is administered, a ~~qualified~~ physician is ~~immediately~~ available in the facility to provide care in the event of a medical emergency;

(2) a roster of practitioners with a delineation of current surgical and anesthesia privileges is available and maintained for the service;

(3) an on-call schedule of surgeons with privileges to be available at all times for emergency surgery and for post-operative clinical management is maintained;

(4) the operating room is supervised by a ~~qualified~~ registered nurse or doctor of medicine or osteopathy; and

(5) an operating room register which shall include date of the operation, name and patient identification number, names of surgeons and surgical assistants, name of anesthetists, type of anesthesia given, pre- and post-operative diagnosis, type and duration of surgical procedure, and the presence or absence of complications in surgery is maintained.

History Note: *Authority G.S. [~~131E-75(b);~~] ~~131E-79;~~ 131E-85; 143B-165;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. August 1, 2023.

10A NCAC 13B .4801 is readopted with changes as published in 36:12 NCR 1029-1032 as follows:

SECTION .4800 - DIAGNOSTIC IMAGING

10A NCAC 13B .4801 ORGANIZATION

(a) Imaging services shall be under the supervision of a full-time radiologist, consulting radiologist, or a ~~physician~~ physician. ~~experienced in the particular imaging modality and the~~ [~~The~~] ~~physician in charge~~ ~~must~~ [~~shall~~] ~~have the credentials required by facility policies.~~

(b) ~~Activities of the imaging service may include radio-therapy.~~ Radio-therapy is a type of imaging service.

(c) All imaging equipment shall be operated under professional supervision by ~~qualified~~ personnel trained in the use of imaging equipment and knowledgeable of all applicable safety precautions required by the North Carolina Department of ~~Environment and Natural Resources,~~ Health and Human Services, Division of ~~Environmental~~ Health Service Regulation, Radiation Protection ~~Section.~~ Section set forth in 10A NCAC 15, hereby incorporated by reference including subsequent amendments. ~~Copies of regulations are available from the N.C. Department of Environment and Natural Resources, Radiation Protection Section, 3825 Barrett Drive, Raleigh, NC 27609 at a cost of sixteen dollars ($16.00) each~~.

History Note: *Authority G.S. [~~131E-75(b);~~] ~~131E-79;~~ 143B-165;*
RRC objection due to lack of statutory authority and ambiguity Eff. July 13, 1995;
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. August 1, 2023.

10A NCAC 13B .4805 is readopted with changes as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .4805 SAFETY

(a) The facility shall require that all imaging equipment is operated under the supervision of a physician and by qualified personnel.

(b) The facility shall require that ~~proper~~ caution is exercised to protect all persons from exposure to radiation.

~~(c) Safety inspections of the imaging department, including equipment, shall be conducted by the North Carolina Division of Environmental Health, [Health Service Regulation,] Radiation Protection Services Section. Copies of the report shall be available for review by the Division.~~

~~(d)~~(c) The governing authority shall appoint a radiation safety committee. ~~The committee shall include but is not limited to:~~ [~~include:~~]

~~(1) a physician experienced in the handling of radio-active isotopes and their therapeutic use; and~~

~~(2) other representatives of the medical staff.~~

~~(e)~~(d) All radio-active isotopes, whether for diagnostic, therapeutic, or research purposes shall be received, handled, and disposed of in accordance with the requirements of the North Carolina Department of ~~Environment and Natural Resources,~~ Health and Human Services, Division of ~~Environmental Health,~~ Health Service Regulation, Radiation Protection ~~Services Section.~~ Section set forth in 10A NCAC 15, hereby incorporated by reference including subsequent amendments. ~~Copies of regulations are available from the North Carolina Department of Environment, Health, and Natural Resources, Division of Radiation Protection, 3825 Barrett Drive, Raleigh, NC 27609 at a cost of six dollars ($6.00) each.~~

History Note: *Authority G.S. [~~131E-75(b);~~] ~~131E-79;~~ 143B-165;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. August 1, 2023.

10A NCAC 13B .5102 is readopted with changes as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .5102 POLICY AND PROCEDURES

(a) Each facility department or service shall establish and maintain the following written infection control policies and ~~procedures. These shall include but are not limited to:~~ [~~include:~~] procedures:

(1) the role and scope of the service or department in the infection control program;

(2) the role and scope of surveillance activities in the infection control program;

(3) the methodology used to collect and analyze data, maintain a surveillance program on nosocomial infection, and the control and prevention of infection;

(4) the specific precautions to be used to prevent the transmission of infection and isolation methods to be utilized;

(5) the method of sterilization and storage of equipment and supplies, including the reprocessing of disposable items;

(6) the cleaning of patient care areas and equipment;

(7) the cleaning of non-patient care areas; and

(8) exposure control plans.

(b) The infection control committee shall approve all infection control policies and procedures. The committee shall review all policies and procedures ~~at least~~ every three years and indicate the last date of review.

(c) The infection control committee shall meet ~~at least~~ quarterly and maintain minutes of meetings.

History Note: *Authority G.S. [~~131E-75(b);~~] ~~131E-79;~~ 143B-165;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff August 1, 2023.

10A NCAC 13B .5105 is readopted with changes as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .5105 STERILE SUPPLY SERVICES

The facility shall provide for the following:

(1) decontamination and sterilization of equipment and supplies;

(2) monitoring of sterilizing equipment on a routine schedule;

(3) establishment of policies and procedures for the use of disposable items; and

(4) establishment of policies and procedures addressing shelf life of stored sterile items.

History Note: *Authority G.S. [~~131E-75(b);~~] ~~131E-79;~~ 143B-165;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. August 1, 2023.

10A NCAC 13B .5406 is readopted with changes as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .5406 DISCHARGE CRITERIA FOR INPATIENT REHABILITATION FACILITIES OR UNITS

(a) Discharge planning shall be an integral part of the patient's treatment plan and shall begin upon admission to the facility. After ~~established~~ goals of care have been reached, or a determination by the interdisciplinary care team has been made ~~that care~~ ~~in a less intensive setting would be appropriate,~~ to return to the setting from which the patient was admitted, or that further progress is unlikely, the patient shall be discharged to ~~an appropriate setting.~~ another inpatient or residential health care facility that can address the patient's needs including skilled nursing homes, assisted living facilities, nursing homes, or other hospitals. Other reasons for discharge may include an inability or unwillingness of patient or family to cooperate with the planned therapeutic program or medical complications that preclude a further intensive rehabilitative effort. The facility shall involve the patient, family, staff ~~members~~ members, and ~~referral sources~~ community-based services such as home health services, hospice or palliative care, respiratory services, rehabilitation services to include occupational therapy, physical therapy, and speech therapy, end stage renal disease, nutritional, medical equipment and supplies, transportation services, meal services, and household services such as housekeeping in discharge planning.

(b) The case manager shall facilitate the discharge or transfer process in coordination with the facility social worker.

(c) If a patient is being referred to another facility for further care, ~~appropriate~~ documentation of the patient's current status shall be forwarded with the patient. A ~~formal~~ discharge summary shall be forwarded within 48 hours following discharge and shall include the reasons for referral, the diagnosis, functional limitations, services provided, the results of services, referral action ~~recommendations~~ recommendations, and activities and procedures used by the patient to maintain and improve functioning.

History Note: *Authority G.S. [~~131E-75(b);~~] ~~131E-79;~~ 143B-165;*
Eff. March 1, ~~1996.~~ 1996;
Readopted Eff. August 1, 2023.

10A NCAC 13B .5408 is readopted with changes as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .5408 COMPREHENSIVE INPATIENT REHABILITATION PROGRAM STAFFING REQUIREMENTS

(a) The staff of the inpatient rehabilitation facility or unit shall ~~include at a minimum:~~ include:

(1) the inpatient rehabilitation facility or unit shall be supervised by a rehabilitation ~~nurse.~~ nurse as defined in Rule .5401 of this Section. The facility shall ~~identify the nursing skills necessary to meet the needs of the rehabilitation patients in the unit and~~ assign staff qualified to meet ~~those needs;~~ the needs of the patient;

(2) the minimum nursing hours per patient in the rehabilitation unit shall be 5.5 nursing hours per patient day. At no time shall direct care nursing staff be less than two full-time equivalents, one of which must be a registered nurse;

(3) the inpatient rehabilitation unit shall employ or provide by contractual agreements ~~sufficient therapist~~ therapists to provide ~~a minimum of~~ three hours of specific (physical, occupational or speech) or combined rehabilitation therapy services per patient day;

~~(4) physical therapy assistants and occupational therapy assistants shall be supervised on site by physical therapists or occupational therapists;~~

~~(5)~~(4) rehabilitation aides shall have documented training appropriate to the activities to be performed and the occupational licensure laws of his or her supervisor. ~~The overall responsibility for the on-going supervision and evaluation of the rehabilitation aide remains with the registered nurse as identified in Subparagraph (a)(1) of this Rule.~~ Supervision by the physical therapist or by the occupational therapist is limited to that time when the therapist is on-site and directing the rehabilitation activities of the aide; and

~~(6)~~(5) hours of service by the rehabilitation aide are counted toward the required nursing hours when the aide is working under the supervision of the nurse. Hours of service by the rehabilitation aide are counted toward therapy hours during that time the aide works under the immediate, on-site supervision of the physical therapist or occupational therapist. Hours of service shall not be dually counted for both services. Hours of service by rehabilitation aides in performing nurse-aide duties in areas of the facility other than the rehabilitation unit shall not be counted toward the 5.5 hour minimum nursing requirement described for the rehabilitation unit.

(b) Additional personnel shall be provided as required to meet the needs of the patient, as defined in the comprehensive inpatient rehabilitation evaluation.

History Note: *Authority G.S. [~~131E-75(b);~~] ~~131E-79;~~ 143B-165;*
RRC Objection due to lack of statutory authority Eff. January 18, 1996;
Eff. May 1, ~~1996.~~ 1996;
Readopted Eff. August 1, 2023.

10A NCAC 13B .5411 is repealed through readoption with changes as published in 36:12 NCR 1029-1032 as follows:

10A NCAC 13B .5411 PHYSICAL FACILITY REQUIREMENTS/INPATIENT REHABILITATION FACILITIES OR UNIT

History Note: *Authority G.S. ~~131E-79;~~ 143B-165;*
Eff. March 1, ~~1996.~~ 1996;
Repealed Eff. August 1, 2023.