

# *The* **NORTH CAROLINA REGISTER**

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**EXECUTIVE ORDER**

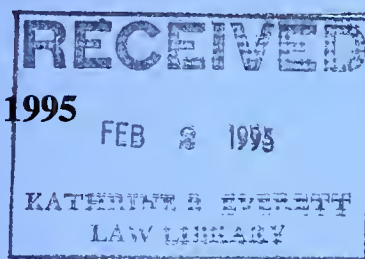
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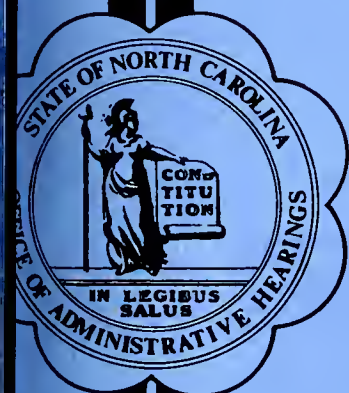
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**ISSUE DATE: February 1, 1995**



**Volume 9 • Issue 21 • Pages 1697 - 1882**



## INFORMATION ABOUT THE NORTH CAROLINA REGISTER AND ADMINISTRATIVE CODE

### **NORTH CAROLINA REGISTER**

The *North Carolina Register* is published twice a month and contains information relating to agency, executive, legislative and judicial actions required by or affecting Chapter 150B of the General Statutes. All proposed administrative rules and notices of public hearings filed under G.S. 150B-21.2 must be published in the Register. The Register will typically comprise approximately fifty pages per issue of legal text.

State law requires that a copy of each issue be provided free of charge to each county in the state and to various state officials and institutions.

The *North Carolina Register* is available by yearly subscription at a cost of one hundred and five dollars (\$105.00) for 24 issues. Individual issues may be purchased for eight dollars (\$8.00).

Requests for subscription to the North Carolina Register should be directed to the Office of Administrative Hearings, P. O. Drawer 27447, Raleigh, N. C. 27611-7447.

### **ADOPTION, AMENDMENT, AND REPEAL OF RULES**

The following is a generalized statement of the procedures to be followed for an agency to adopt, amend, or repeal a rule. For the specific statutory authority, please consult Article 2A of Chapter 150B of the General Statutes.

Any agency intending to adopt, amend, or repeal a rule must first publish notice of the proposed action in the *North Carolina Register*. The notice must include the time and place of the public hearing (or instructions on how a member of the public may request a hearing); a statement of procedure for public comments; the text of the proposed rule or the statement of subject matter; the reason for the proposed action; a reference to the statutory authority for the action and the proposed effective date.

Unless a specific statute provides otherwise, at least 15 days must elapse following publication of the notice in the *North Carolina Register* before the agency may conduct the public hearing and at least 30 days must elapse before the agency can take action on the proposed rule. An agency may not adopt a rule that differs substantially from the proposed form published as part of the public notice, until the adopted version has been published in the *North Carolina Register* for an additional 30 day comment period.

When final action is taken, the promulgating agency must file the rule with the Rules Review Commission (RRC). After approval by RRC, the adopted rule is filed with the Office of Administrative Hearings (OAH).

A rule or amended rule generally becomes effective 5 business days after the rule is filed with the Office of Administrative Hearings for publication in the North Carolina Administrative Code (NCAC).

Proposed action on rules may be withdrawn by the promulgating agency at any time before final action is taken by the agency or before filing with OAH for publication in the NCAC.

### **TEMPORARY RULES**

Under certain emergency conditions, agencies may issue temporary rules. Within 24 hours of submission to OAH, the Codifier of Rules must review the agency's written statement of findings of fact for the temporary rule pursuant to the provisions in G.S. 150B-21.1. If the Codifier determines that the findings meet the criteria in 150B-21.1, the rule is entered into the NCAC. If the Codifier determines that the findings do not meet the criteria, the rule is returned to the agency. The agency may supplement its findings and resubmit the temporary rule for an additional review or the agency may request that it will remain with its initial position. The Codifier, thereafter, enters the rule into the NCAC. A temporary rule becomes effective either when the Codifier of Rules enters the rule in the Code or on the sixth business day after the agency resubmits the rule without change. The temporary rule is in effect for the period specified in the rule or 180 days, whichever is less. An agency adopting a temporary rule begins rule-making procedures on the permanent rule at the same time the temporary rule is filed with the Codifier.

### **NORTH CAROLINA ADMINISTRATIVE CODE**

The North Carolina Administrative Code (NCAC) is a compilation and index of the administrative rules of 25 state agencies and occupational licensing boards. The NCAC comprises approximately 15,000 letter size, single spaced pages of material of which approximately 35% is changed annually. Compilation and publication of the NCAC is mandated by G.S. 150B-21.18.

The Code is divided into Titles and Chapters. Each state agency is assigned a separate title which is further broken down by chapters. Title 21 is designated for occupational licensing boards.

The NCAC is available in two formats.

- (1) Single pages may be obtained at a minimum cost of \$2.50 for 10 pages or less, plus fifty cents (\$0.15) per each additional page.
- (2) The full publication consists of 53 volumes, totaling in excess of 15,000 pages. It is supplemented monthly by replacement pages. A one year subscription to the publication including supplements can be purchased for seven hundred and fifty dollars (\$750.00). Individual volumes may also be purchased with supplement service. New subscriptions for supplements to the initial publication are available.

Requests for pages of rules or volumes of the NCAC should be directed to the Office of Administrative Hearings.

### **CITATION TO THE NORTH CAROLINA REGISTER**

The *North Carolina Register* is cited by volume, issue, page number and date. 1:1 NCR 101-201, April 1, 1986 refers to Volume 1, Issue 1, pages 101 through 201 of the *North Carolina Register* issued on April 1, 1986.

FOR INFORMATION CONTACT: Office of Administrative Hearings, ATTN: Rules Division, P.O. Drawer 27447, Raleigh, North Carolina 27611-7447, (919) 733-2678.

# NORTH CAROLINA REGISTER

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P. O. Drawer 27447  
Raleigh, North Carolina 27611-7447  
(919) 733-2678*

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# NORTH CAROLINA REGISTER

## Publication Schedule

(November 1994 - September 1995)

Volume and Issue Number	Issue Date	Last Day for Filing	Last Day for Electronic Filing	Earliest Date for Public Hearing 15 days from notice	* End of Required Comment Period 30 days from notice	Last Day to Submit to RRC	** Earliest Effective Date
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*This table is published as a public service, and the computation of time periods are not to be deemed binding or controlling. Time is computed according to 26 NCAC 2B .0103 and the Rules of Civil Procedure, Rule 6.*

*\* An agency must accept comments for at least 30 days after the proposed text is published or until the date of any public hearing, whichever is longer. See G.S. 150B-21.2(f) for adoption procedures.*

*\*\* The "Earliest Effective Date" is computed assuming that the agency follows the publication schedule above, that the Rules Review Commission approves the rule at the next calendar month meeting after submission, and that RRC delivers the rule to the Codifier of Rules five (5) business days before the 1st day of the next calendar month.*



**EXECUTIVE ORDER NO. 67  
EXTENSION OF EXECUTIVE  
ORDER NO. 1  
NORTH CAROLINA BOARD OF ETHICS**

Pursuant to the authority vested in me as Governor by the Constitution and laws of North Carolina, **IT IS ORDERED:**

Executive Order No. 1, North Carolina Board of Ethics, as amended by Executive Order No. 14, is hereby extended without amendment for two years.

This Executive Order is effective immediately.

Done in the City of Raleigh this the 6th day of January, 1995.

**EXECUTIVE ORDER NO. 68  
ESTABLISHING THE NORTH CAROLINA  
INFORMATION HIGHWAY COUNCIL OF  
ADVISORS AND THE NORTH CAROLINA  
INFORMATION HIGHWAY POLICY  
COMMITTEE**

WHEREAS, the successful implementation of the North Carolina Information Highway is critical to improving the economic vitality of the State through the employment of information technology for economic development and to enhancing the quality of life of all citizens, particularly in the delivery of health services, the education of its citizens, the training of its workforce, the providing of greater public safety through the development of an integrated criminal justice information system, the offering of more integrated, effective and efficient services to citizens by state and local governments and the deployment of information technology to citizens utilizing our libraries as gateways; and

WHEREAS, it is important that the North Carolina Information Highway be developed from a broad perspective utilizing the knowledge of a diverse group of citizens at the advisory level and a group of internal and external public officials as a policy committee.

NOW, THEREFORE, by the power vested in me as Governor by the laws and Constitution of the State of North Carolina, **IT IS ORDERED:**

**Section 1. Establishment.**

The North Carolina Information Highway Council of Advisors and the North Carolina Information

Highway Policy Committee are hereby established.

**Section 2. Definitions.**

For the purposes of this Executive Order, the following definitions apply:

- (A) The term "Council" means the North Carolina Information Highway Council of Advisors;
- (B) The term "Policy Committee" means the North Carolina Information Highway Policy Committee;
- (C) "North Carolina Information Highway" (NCIH) means the advanced telecommunications networks operating with high-speed increased capacity capabilities and any other voice, data, video, imaging or other network application that might be interoperable or interconnected with the North Carolina Information Highway.

**Section 3. Purpose and Intent.**

The purpose of the Council and the Policy Committee is to advise the Governor, the Information Resources Management Commission (IRMC), the North Carolina General Assembly and the Office of the State Controller on any matters pertaining to the NCIH. The Policy Committee shall also make such recommendations as it deems necessary to the Information Highway Grants Advisory Council.

**Section 4. Membership.**

A. The Council shall consist of 30 members. The Speaker of the House shall appoint 5 members and the President Pro Tem of the Senate shall appoint 5 members. The Governor shall request the Chair of the IRMC, the Chair of the North Carolina Utilities Commission, the Chair of the Policy Committee, the Chief Executive Officer of the Microelectronics Center of North Carolina (MCNC) and the State Controller to serve as ex-officio members of the Council. The Governor shall appoint the remaining 15 members of the Council, including the Chair. The appointing authorities shall consider interest in the State's telecommunications policies related to the ability of the State to provide responsive and cost-effective services to its citizens. To the extent possible, efforts should be made to represent all geographic areas of the State.

Of the Governor's appointees, six shall be professionals from private industry and shall be from the ranks of leaders in either the fields of information or telecommunications technology or senior business leaders with experience in applying

these technologies and services on an enterprise-wide basis. These members shall also be available to serve as an additional advisory body for offering expert guidance and counsel regarding the implementation, application and management of resources and services for information technology and telecommunications to the Governor, the State Controller and the IRMC, as was previously performed by the Governor's Committee on Data Processing. To augment this group for accomplishing its expanded responsibilities, the State Controller may appoint up to four individuals from non-profit organizations, local or federal government agencies, universities or research institutions to serve with it when meeting as an additional advisory body. A member of the Council of Advisors shall be authorized to sit on the IRMC. This person should fill the seat formerly assigned to the Governor's Committee on Data Processing.

The NCIH Council of Advisors shall meet at least twice yearly. They will work with the Policy Committee to involve the business, educational, and governmental communities and the citizens at large to understand the Information Highway, applications that can use these information networks and their benefits to the State of North Carolina.

B. Members of the Policy Committee and its Chair shall be appointed by the Governor. The Policy Committee shall be composed of individuals who represent agencies of the State of North Carolina including, but not limited to, representatives from the Council of State and Cabinet agencies, the University of North Carolina System, and the North Carolina Community College System. A staff member from the IRMC, a staff member from the State Controller's Office and two staff members of the MCNC Advanced Networking Group shall be appointed by the Governor. Representatives of public or private non-profits should be considered for membership. Membership on this Policy Committee should reflect the membership of the former NCIH Planning Committee. The Committee may form subcommittees as desired to help in the performance of its duties and responsibilities.

The Policy Committee shall provide guidance and direction to the NCIH Council of Advisors. It shall use its experience and knowledge to provide unified recommendations on NCIH future directions to the IRMC, to recommend proposed NCIH standards to the IRMC, to integrate applications among agencies, to promote interoperability, and to coordinate integration efforts across state and local government agencies.

The Policy Committee, the Office of the State Controller and the IRMC should work closely together, particularly during the critical controlled introduction phase (five years) of the NCIH, when they should be in constant communication. To facilitate this, it is requested that the State Controller encourage his NCIH staff to attend all meetings of the Policy Committee. The Office of the State Controller and the Information Resources Management Commission will continue to have the authority over telecommunications currently identified for each by the General Statutes of North Carolina.

C. Members of the Council and the Policy Committee shall serve two-year terms. Vacancies shall be filled by the original appointing authority for the balance of the unexpired terms.

D. A majority of the members of the Council shall constitute a quorum for the transaction of business of the Council. A majority of the members of the Policy Committee shall constitute a quorum for the transaction of business of the Policy Committee.

E. The Council members shall receive no salary. Subsistence and travel expenses are available for those who could not serve without reimbursement, in accordance with the N.C.G.S. 120-3.1, 138-5 and 138-6, as applicable. Members of the General Assembly will be requested to use their General Assembly funds to reimburse them for their expenses. Policy Committee members will receive any reimbursement from their respective agencies.

F. The staff for the Council shall be the Policy Committee, staff for the Policy Committee shall be provided by the Office of the Governor, the IRMC and the Office of the State Controller. State entities who have members on the Policy Committee may be requested to provide some staff assistance to the Policy Committee.

### **Section 5. Responsibilities.**

The NCIH Council and the Policy Committee shall file a report with the Governor, the IRMC and the General Assembly by June 1995 and thereafter at least twice per year. The report may make recommendations on the NCIH implementation in the public high schools and elementary schools of North Carolina, the libraries, the criminal justice system, intergovernmental and economic development activities, health service delivery and any other recommendations they might choose to make about the planning implementation of the NCIH. Upon request, the Council shall also report to the Education Oversight

Committee and any other General Assembly Oversight Committee.

**Section 6. Funding.**

Monies for the carrying out of this Executive Order shall come from the funds of the State already appropriated. The Council and the Policy Committee may also receive funds from other public and/or private for-profit and nonprofit foundations.

**Section 7. Effect on Other Executive Orders.**

All prior Executive Orders or portions of prior Executive Orders inconsistent herewith are rescinded.

This order shall become effective immediately and remain in effect until rescinded.

Done in the Capital City of Raleigh, North Carolina, this the 6th day of January, 1995.



*This Section contains public notices that are required to be published in the Register or have been approved by the Codifier of Rules for publication.*

U.S. Department of Justice

Civil Rights Division

Voting Section

P.O. Box 66128

Washington, D.C. 20035-6128

DLP:MAP:RPR:tlb

DJ 166-012-3

94-4340

January 9, 1995

Jesse L. Warren, Esq.

City Attorney

P. O. Box 3136

Greensboro, North Carolina 27402-3136

Dear Mr. Warren:

This refers to the annexation (Ordinance No. 94-108) and the designation of the annexed area to District 2 of the City of Greensboro in Guilford County, North Carolina, submitted to the Attorney General pursuant to Section 5 of the Voting Rights Act of 1965, as amended, 42 U.S.C. 1973c. We received your submission on November 9, 1994.

The Attorney General does not interpose any objection to the specified changes. However, we note that Section 5 expressly provides that the failure of the Attorney General to object does not bar subsequent litigation to enjoin the enforcement of the changes. See the Procedures for the Administration of Section 5 (28 C.F.R. 51.41).

Sincerely,

Deval L. Patrick

Assistant Attorney General

Civil Rights Division

By:

John K. Tanner

Acting Chief, Voting Section

## TITLE 4 - DEPARTMENT OF COMMERCE

*Notice* is hereby given in accordance with G.S. 150B-21.2 that the North Carolina Banking Commission intends to adopt rules cited as 4 NCAC 3C .0112, .1701 - .1705, .1801 - .1802; amend 3C .0101, .0107, .0111, .0201 - .0204, .0301, .0801 - .0804, .0807, .0901, .1001, .1101 and .1301 - .1302.

*The proposed effective date of this action is June 1, 1995.*

*The public hearing will be conducted at 9:00 a.m. on March 3, 1995 at the Dobbs Building, 430 North Salisbury Street, Room 6227, Raleigh, North Carolina.*

### *Reason for Proposed Action:*

**4 NCAC 3C .0101** - This amendment distinguishes the physical location and the mailing address of the Commissioner of Banks.

**4 NCAC 3C .0107** - This amendment provides that bank certificates must be posted in plain view of its customers.

**4 NCAC 3C .0111** - This amendment distinguishes the physical location and the mailing address of the Commissioner of Banks.

**4 NCAC 3C .0112** - This Rule establishes guidelines for amendments to bank charters regarding director liability.

**4 NCAC 3C .0201** - This amendment distinguishes the physical location and the mailing address of the Commissioner of Banks. In addition, it eliminates the requirement that the Commissioner of Banks publish in the newspaper a notice that a bank application was filed, and requires that branch certificates be posted in plain view of its customers.

**4 NCAC 3C .0202** - This amendment substitutes limited service facility for teller's window and distinguishes the physical location and mailing address of the Commissioner of Banks.

**4 NCAC 3C .0203** - This amendment provides the rule number that this rule references.

**4 NCAC 3C .0204** - This amendment eliminates the requirement that the Commissioner of Banks publish in the newspaper notice of a request for a branch to convert to a limited service facility. In addition, it distinguishes the physical location and the mailing address of the Commissioner of Banks.

**4 NCAC 3C .0301** - This amendment distinguishes the physical location and the mailing address of the Commissioner of Banks. In addition, it eliminates the requirement that the Commissioner of Banks publish in the newspaper a notice of an application to change the location of a main office, branch, or limited service facility.

**4 NCAC 3C .0801** - This amendment distinguishes the physical location and the mailing address of the Commissioner of Banks.

**4 NCAC 3C .0802** - This amendment distinguishes the physical location and the mailing address of the Commissioner of Banks. In addition, it clarifies which banks must have their proposed depositories approved by the Commissioner of Banks.

**4 NCAC 3C .0803** - This amendment distinguishes the physical location and the mailing address of the Commissioner of Banks.

**4 NCAC 3C .0804** - This amendment distinguishes the physical location and the mailing address of the Commissioner of Banks. In addition, it provides that two different forms will be used for approval of a banks investment limitation and loan limitation.

**4 NCAC 3C .0807** - This amendment adds joint venture as one of the types of entities a bank may seek approval to invest in.

**4 NCAC 3C .0901** - This amendment increases the aggregate amount of direct and indirect liability from ten thousand dollars (\$10,000) to twenty thousand dollars (\$20,000) as being, the threshold amount for omitting the indirect liability ledger.

**4 NCAC 3C .1001** - This amendment changes the requirements for determining which borrowers must submit financial statements from those receiving ten thousand dollars (\$10,000) or more in unsecured loans to those receiving twenty thousand dollars (\$20,000) or more in unsecured loans or extensions of credit. It sets out the form of the financial statements and provides two exceptions to the requirements of filing financial statements. In addition, this rule provides an alternative (real property tax notice) to obtaining a real estate appraisal and three acceptable approaches to determining the value of real property.

**4 NCAC 3C .1101** - This amendment provides definitions for terminology used in Rules .1102, .1103, .1104, and .1105.

**4 NCAC 3C .1301** - This amendment changes the required vacation period that banks must provide to its employees from six to five working days.

**4 NCAC 3C .1302** - This amendment establishes the conditions that must be met when a bank wants to establish a stock option or stock purchase plan for its directors, officers, and employees. It

provides the information to be provided when submitting a request for approval of the plan. In addition, it provides the limitation for the types of stock and number of shares to be issued under the plans.

**4 NCAC 3C .1701** - This rule provides the definitions of types of services that banks may establish pursuant to Rules .1702, .1703, .1704, and .1705.

**4 NCAC 3C .1702** - This rule allows a nonresident bank to establish loan production offices in North Carolina. It indicates the activities or services that a nonresident bank may or may not participate in or provide.

**4 NCAC 3C .1703** - This rule allows a nonresident bank to establish lockbox services in North Carolina. It establishes the criteria a nonresident bank must meet as well as the activities that they may participate in.

**4 NCAC 3C .1704** - This rule allows a nonresident bank to establish a trust representative office in North Carolina. It indicates the activities and services that a nonresident bank may or may not participate in or provide.

**4 NCAC 3C .1705** - This rule allows a nonresident bank to establish a business development office in North Carolina. It indicates the activities and services that a nonresident bank may or may not participate in or provide.

**4 NCAC 3C .1801** - This rule allows a state bank to provide courier or messenger services to its customers pursuant to a written agreement. It also establishes the contents of the agreement.

**4 NCAC 3C .1802** - This rule sets out disclosure requirements for state banks providing courier or messenger services.

**Comment Procedures:** Comments must be submitted in writing not later than Friday, March 3, 1995. Written comments should be directed to:

Garistine M. Davis, Counsel  
North Carolina Banking Commission  
P.O. Box 29512  
Raleigh, North Carolina 27626-0512.

## CHAPTER 3 - BANKING COMMISSION

### SUBCHAPTER 3C - BANKS

#### SECTION .0100 - ORGANIZATION AND CHARTERING

##### .0101 APPLICATION

A new bank, industrial bank or trust company shall be incorporated and chartered in the manner

prescribed in G.S. 53-2 through G.S. 53-8 and no other way. A charter application, on a form approved, together with a copy of the proposed Articles of Incorporation and payment of the prescribed fee, must be filed with The Commissioner of Banks located at 430 North Salisbury Street, Dobbs Building, Suite 6210, Raleigh, North Carolina 27611. The mailing address is P.O. Box 29512, Raleigh, North Carolina 27626-0512.

~~The Commissioner of Banks  
P.O. Box 29512~~

~~Raleigh, North Carolina 27626-0512.~~

Statutory Authority G.S. 53-2; 53-92; 53-122(3).

##### .0107 BANK CERTIFICATE

Upon final action approving an application for a new bank the Commissioner of Banks shall issue to the bank a Bank Certificate. A bank shall post its Bank Certificate in plain view of its customers in its main office. A Form 45 is used for that purpose and contains a certification that all statutory requirements have been satisfied and is an authorization to begin business.

Statutory Authority G.S. 53-8; 53-92.

##### .0111 NATIONAL BANK CONVERSION

(a) A national bank may apply for authority to convert to a state bank. An application for conversion must be made on Form 30. The application for conversion, together with a copy of the proposed articles of incorporation and payment of the prescribed fee, must be filed with The Commissioner of Banks located at 430 North Salisbury Street, Dobbs Building, Suite 6210, Raleigh, North Carolina 27611. The mailing address is P.O. Box 29512, Raleigh, North Carolina 27626-0512.

~~The Commissioner of Banks  
P.O. Box 29512~~

~~Raleigh, North Carolina 27626-0512.~~

(b) Upon receipt of a copy of the articles of incorporation and the completed application for conversion, the Commissioner will make an examination into all the facts connected with the conversion. Following the completion of that examination the Commissioner will issue a written decision approving or disapproving the application.

(c) Upon approval by the Commissioner of Banks, he will forward to the Secretary of State for appropriate filing the articles of incorporation along with the certification of approval. The Commissioner will issue to the bank a Bank



Certificate (Form 45) and any Branch Certificate (Form 47) as needed.

*Statutory Authority G.S. 53-2; 53-3; 53-4; 53-5; 53-14; 53-104; 53-122(3).*

**0112 ELIMINATION OF DIRECTOR LIABILITY**

(a) Bank charter amendments limiting director liability pursuant to G.S. 55-2-02(b)(3) must provide that director liability is not eliminated or limited with regards to acts or omissions where the elimination of personal liability of directors would be contrary to the provisions of G.S. 53-1 et. seq.

(b) A new bank, industrial bank, or trust company may submit proposed bank charter amendments to the Commissioner for review prior to an approval and giving the required notice to shareholders.

*Statutory Authority G.S. 53-104, 53-115, 55-202.*

**SECTION .0200 - BRANCHES AND LIMITED SERVICE FACILITIES**

**0201 ESTABLISHMENT OF BRANCHES AND LIMITED SERVICE FACILITIES**

Banks may establish branches or limited service facilities upon written approval of the Commissioner of Banks.

(1) Application. An application to establish a branch bank or limited service facility must be submitted in writing on Form 30. The application, together with the prescribed fee, must be filed with The Commissioner of Banks located at 430 North Salisbury Street, Dobbs Building, Suite 6210, Raleigh, North Carolina 27611. The mailing address is P.O. Box 29512, Raleigh, North Carolina 27626-0512.

~~The Commissioner of Banks  
P.O. Box 29512  
Raleigh, North Carolina 27626-0512.~~

(2) Notice of filing of an application. ~~Upon acceptance of an application for filing, the Commissioner of Banks will publish a notice of the filing of the application in a newspaper published in the city, town or county where the branch or limited service facility is proposed to be located. A copy of the notice will be mailed~~ Upon acceptance of an application for filing, the Commissioner of Banks will

mail a notice of the filing of the application to each state-chartered bank operating a banking office in the community to be served by the proposed branch or limited service facility. A copy of the notice will be mailed to the Regional Administrator of National Banks for the National Bank Region for North Carolina.

- (3) Written comments. Any interested person may submit to the Commissioner of Banks written comments and information on an application within 14 days after the notice has been published as provided in Paragraph (2) of this Rule. All written comments received during the comment period will become part of the official record compiled with respect to the application. The Commissioner of Banks may extend the comment period if he determines that there are extenuating circumstances.
- (4) Examination by Commissioner. Upon receipt of a completed application, the Commissioner of Banks will conduct an examination into all the facts connected with the establishment of a branch or limited service facility.
- (5) Action by Commissioner. No final decision may be made by the Commissioner of Banks until the comment period has expired. The final decision of the Commissioner of Banks on an application will be in writing and include findings of fact and conclusions of law.
- (6) Notification of Commissioner's action. The applicant and all persons who have made written requests for such notice will be given notice of the Commissioner of Banks' final decision on each application.
- (7) Request for review by Banking Commission. The applicant or any interested person may request the State Banking Commission to review the decision of the Commissioner of Banks with respect to an application to establish a branch or limited service facility within 14 days from the time the Commissioner of Banks issues his written decision. The request for review must be in writing and must be sent to the address shown in Paragraph (1) of this Rule.
- (8) Review by Banking Commission. When requested by the applicant or any

interested person, the decision of the Commissioner of Banks will be reviewed at a public hearing by the State Banking Commission at its next regular or called meeting. Following the public hearing, the State Banking Commission will issue its final order approving, modifying or disapproving the decision of the Commissioner of Banks. Notice of the public hearing will be published in a newspaper published in the city, town or county where the proposed branch or limited service facility is to be located at least ten days prior to the scheduled hearing.

- (9) Decision by Commissioner final. If there has been no written request for review within the 14-day period as provided in Paragraph (7) of this Rule, the decision issued by the Commissioner of Banks will become final with respect to the application. Upon final action approving an application for a new branch the Commissioner of Banks shall issue to the branch or limited service facility a branch certificate which is to be posted in plain view of its customers.
- (10) Commissioner to set requirements. When a bank acquires one or more branches or limited service facilities in connection with a reorganization in which the Commissioner of Banks or other depository financial institution regulator has found one or more depository financial institutions to be in an insolvent, unsafe or unsound condition, the Commissioner of Banks shall set all requirements pertaining to notice and publication, time limitations, and any comment period.

Statutory Authority G.S. 53-4; 53-14; 53-62; 53-92.

## .0202 DISCONTINUANCE

No bank may close a branch without the written approval of the Commissioner of Banks.

- (1) Procedure. The procedures provided in G.S. 53-62(e) must be followed in connection with ~~any branch or teller's window closing~~ any closing of a branch or limited service facility not subject to Rule .0203 of this Section. The required public notice to be published must be approved by the Commissioner of Banks

prior to publication.

- (2) Written comments. Any interested person may submit to the Commissioner of Banks written comments and information on an application to discontinue within 14 days after the last notice has been published as required by G.S. 53-62(e). All written comments received during the comment period will become part of the official record and be compiled with respect to the application. The Commissioner of Banks may extend the comment period if he determines that there are extenuating circumstances.
- (3) Examination by Commissioner. Upon receipt of an application, the Commissioner of Banks will conduct an examination into all the facts connected with the request to close a branch. The Commissioner of Banks will hold a public hearing as provided in G.S. 53-62(e) if there has been an appropriate request by an interested person.
- (4) Action by Commissioner. No final decision may be made by the Commissioner of Banks until the comment period has expired. The final decision of the Commissioner of Banks on an application to discontinue will be issued in writing and include findings of fact and conclusions of law.
- (5) Notification of Commissioner's action. The applicant and all persons who have made written requests for notice will be given notice of the Commissioner of Banks' final decision on each application.
- (6) Request for review by Banking Commission. The applicant or any other interested person may request the State Banking Commission to review the decision of the Commissioner of Banks with respect to an application to discontinue a branch within 14 days from the time the Commissioner of Banks issues his written decision. The request must be in writing and sent to The Commissioner of Banks, P.O. Box 29512, Raleigh, North Carolina 27626-0512 which is located at 430 North Salisbury Street, Dobbs Building, Suite 6210, Raleigh, North Carolina 27611.

The Commissioner of Banks  
P.O. Box 29512  
Raleigh, North Carolina 27626-0512.



- (7) Review by Banking Commission. When requested by the applicant or by any interested person, the decision of the Commissioner of Banks will be reviewed at a public hearing by the State Banking Commission at its next regular or called meeting. Following the public hearing, the State Banking Commission will issue its final order approving, modifying or disapproving the decision of the Commissioner of Banks. Notice of the public hearing will be published in a newspaper published in the city, town or county where the branch is to be discontinued at least ten days prior to the scheduled hearing.
- (8) Decision by Commissioner final. If there has been no written request for review within the 14-day period as provided in Paragraph (6) of this Rule, the decision issued by the Commissioner of Banks will become final with respect to the application to discontinue.
- (9) Commissioner to set requirements. Where a bank discontinues one or more branches in connection with a reorganization in which the Commissioner of Banks or other bank regulator has found one or more banks to be in an insolvent, unsafe, or unsound condition, the Commissioner of Banks shall set all requirements pertaining to notice and publication, time limitations, and any comment period.

Statutory Authority G.S. 53-62.

#### .0204 CONVERSION OF BRANCH TO LIMITED SERVICE FACILITY

(a) A bank may convert a branch to a limited service facility upon written approval of the Commissioner of Banks.

(b) ~~(4)~~ Procedure. Any bank desiring to convert an existing branch to a limited service facility must apply in writing for authority to do so from the Commissioner of Banks and pay the prescribed fee. The letter must identify the name and location of the branch to be converted, the reason for the conversion, the services presently offered at the branch, and the services that will be discontinued upon conversion.

(c) ~~(2)~~ Publication. ~~Upon receipt of a written request for authority to convert a branch to a limited service facility, the Commissioner of Banks will publish once a week for two consecutive weeks in a newspaper published in the city, town or county in which the branch to be converted is located, a public notice of the request to convert. This publication must include the name and location of the branch to be converted, and must identify the services presently offered at the branch that will be discontinued upon conversion. Public notice as required by G.S. 53-62(e) must be given in connection with the conversion of a branch to a limited service facility. The required public notice to be published must be approved by the Commissioner of Banks prior to publication. The publication shall include:~~

- (1) the name and location of the branch to be converted;
- (2) the services presently offered at the branch that will be discontinued upon conversion.

(d) ~~(3)~~ Written comments. Any interested person may submit to the Commissioner of Banks written comments and information on an application to convert a branch to a limited service facility within 14 days after the last notice has been published pursuant to Paragraph (2) of this Rule. All written comments received during the comment period will become part of the official record compiled with respect to the application. The Commissioner of Banks may extend the comment period if he determines that there are extenuating circumstances.

(e) ~~(4)~~ Examination by Commissioner. Upon receipt of an application to convert, the Commissioner of Banks will conduct an examination into all the facts connected with the conversion of a branch. The Commissioner of

Statutory Authority G.S. 53-4; 53-62; 53-92.

#### .0203 DISCONTINUANCE OF A LIMITED SERVICE FACILITY

(a) A bank may close a limited service facility upon 30 days written notice to the Commissioner of Banks at the address set forth in Paragraph (1) of Rule .0201 of this Section, provided that the facility has not within a five year period immediately proceeding the proposed date of closing operated as a branch bank. If the limited service facility which the bank proposes to close has operated as a branch bank within a five year period immediately proceeding the proposed closing date, then the procedure set forth in 4 NCAC 3C .0202 must be followed.

(b) For the purpose of this Rule, any bank and office approved as a "teller's window" prior to July 1, 1989, is considered and will be treated as a limited service facility.



Banks will hold a public hearing if there has been an appropriate request by an interested person.

(f) (5) Action by Commissioner. No final decision may be made by the Commissioner of Banks until the comment period has expired. The final decision of the Commissioner of Banks on a request to convert a branch to a limited service facility will be issued in writing and include findings of fact and conclusions of law.

(g) (6) Notification of Commissioner's Action. The applicant and all persons who have made written requests for notice will be given notice of the Commissioner of Banks' final decision on each application.

(h) (7) Request for Review by Banking Commission. The applicant or any other interested person may request the State Banking Commission to review the decision of the Commissioner of Banks with respect to an application to convert a branch to a limited service facility within 14 days from the time the Commissioner of Banks issues his written decision. The request must be in writing and sent to The Commissioner of Banks, P.O. Box 29512, Raleigh, North Carolina 27626-0512 which is located at 430 North Salisbury Street, Dobbs Building, Suite 6210, Raleigh, North Carolina 27611.

The Commissioner of Banks  
P.O. Box 29512

Raleigh, North Carolina 27626-0512.

(i) (8) Decision by Commissioner Final. If there has been no written request for review within the 14-day period as provided in Paragraph (7) of this Rule, the decision issued by the Commissioner of Banks will become final with respect to the request to convert.

*Statutory Authority G.S. 53-62; 53-92; 53-122(3).*

## SECTION .0300 - CHANGE OF LOCATION

### .0301 CHANGE OF LOCATION OF MAIN OFFICE, BRANCH OR LTD SVC FACILITY

No bank may change the location of a branch, limited service facility or main office without the written approval of the Commissioner of Banks.

- (1) Application. Applications must be in the format required and filed, together with the prescribed fee, shall be filed with: The Commissioner of Banks located at 430 North Salisbury Street, Dobbs Building, Suite 6210, Raleigh, North Carolina 27611. The mailing address is

P.O. Box 29512, Raleigh, North Carolina 27626-0512.

The Commissioner of Banks  
P.O. Box 29512

Raleigh, North Carolina 27626-0512.

- (2) Notice of filing of an application. Upon acceptance of an application for filing the Commissioner of Banks will ~~publish a notice of the filing of the application in a newspaper published in the city, town or county where the branch, limited service facility or main office is to be located.~~ A copy of the notice will be mailed mail a notice of the filing of the application to each state-chartered bank operating a banking office in the community served by the branch, limited service facility or main office. A copy of the notice will be mailed to the Regional Administrator of National Banks for the National Bank Region for North Carolina.
- (3) Written comments. Any interested person may submit to the Commissioner of Banks written comments and information on an application within 14 days after the notice has been published as provided in Subparagraph (2) of this Rule. All written comments received during the comment period will become part of the official record compiled with respect to the application. The Commissioner of Banks may extend the comment period if he determines that there are extenuating circumstances.
- (4) Examination by Commissioner. Upon receipt of a completed application for relocation the Commissioner of Banks will conduct an examination into all the facts connected with the change of location.
- (5) Action by Commissioner. No final decision may be made by the Commissioner of Banks until the comment period has expired. The final decision of the Commissioner of Banks on an application will be issued in writing and will include findings of fact and conclusions of law.
- (6) Notification of Commissioner's action. The applicant and all persons who have made written request for notice, will be given notice of the Commissioner of Banks' final decision on each application.
- (7) Request for review by Banking

Commission. The applicant or any interested person may request the State Banking Commission to review the decision of the Commissioner of Banks with respect to an application to relocate a branch, limited service facility or main office within 14 days from the time the Commissioner of Banks issues his written decision. The request for review must be in writing and must be sent to the address shown in Subparagraph (1) of this Rule.

- (8) Review by Banking Commission. When requested by the applicant or any interested person, the decision of the Commissioner of Banks will be reviewed at a public hearing by the State Banking Commission at its next regular or called meeting. Following the public hearing, the State Banking Commission will issue its final order approving, modifying or disapproving the decision of the Commissioner of Banks. Notice of the public hearing will be published in a newspaper published in the city, town or county where the branch, limited service facility or main office is to be located at least ten days prior to the scheduled hearing.
- (9) Decision by Commissioner final. If there has not been a written request for review within the 14-day period as provided in Subparagraph (7) of this Rule, the decision issued by the Commissioner of Banks will become final with respect to the application.

*Statutory Authority G.S. 53-62; 53-92; 53-122(3).*

## SECTION .0800 - MISCELLANEOUS REPORTS AND APPROVALS

### .0801 OATH OF DIRECTORS

Form 2 incorporates a statutory oath required to be executed by each director of a state bank. The form requires the signature under oath of each director and his address. It must be executed in duplicate annually within 30 days after the election of a director. The forms can be obtained from and one copy must be filed with The Commissioner of Banks located at 430 North Salisbury Street, Dobbs Building, Suite 6210, Raleigh, North Carolina 27611. The mailing address is P.O. Box 29512, Raleigh, North Carolina 27626-0512.

~~The Commissioner of Banks  
430 N. Salisbury Street~~

~~Dobbs Bldg. Box 29512  
Raleigh, N.C. 29626-0512~~

*Statutory Authority G.S. 53-80; 53-81; 53-92.*

### .0802 DEPOSITORY BANKS

Form 3 contains a request to the Commissioner of Banks to approve the proposed depositories of a bank for those banks not subject to the Federal Reserve Board's Regulation D codified at 12 C.F.R. 204. It is required to be filed in duplicate annually by the Board of Directors of each state bank. The form may be obtained from and shall be filed with The Commissioner of Banks located at 430 North Salisbury Street, Dobbs Building, Suite 6210, Raleigh, North Carolina 27611. The mailing address is P.O. Box 29526-0512.

~~The Commissioner of Banks  
430 N. Salisbury Street  
Dobbs Bldg. Box 29512  
Raleigh, N.C. 29626-0512~~

*Statutory Authority G.S. 53-84; 53-92.*

### .0803 OTHER REAL ESTATE

Form 16-A contains a request for the Commissioner of Banks to approve holding for one year real estate acquired by foreclosure, etc., that had not been disposed of by the end of the previous year. It is required to be filed in duplicate annually by the Board of Directors of any state bank owning such real estate. The form may be obtained from and shall be filed with The Commissioner of Banks located at 430 North Salisbury Street, Dobbs Building, Suite 6210, Raleigh, North Carolina 27611. The mailing address is P.O. Box 29512, Raleigh, North Carolina 27626-0512.

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*Statutory Authority G.S. 53-43-(3)c; 53-92.*

### .0804 SUSPENSION OF INVESTMENT AND LOAN LIMITATION

Form 17 and Form 18 ~~contains~~ contain a request for the Commissioner of Banks to approve the suspension of a bank's investment limitation and or its loan limitation, respectively, to a particular borrower for a period of 120 days. The form incorporates the required resolution of the bank's board of directors and must be accompanied by financial statements of the borrower(s) and must be



filed in triplicate. This report and the information contained therein is confidential and neither the report nor any of its contents shall be made available to the public. The form may be obtained from and filed with The Commissioner of Banks located at 430 North Salisbury Street, Dobbs Building, Suite 6210, Raleigh, North Carolina 26711. The mailing address is P.O. Box 29512, Raleigh, North Carolina 27626-0512.

The Commissioner of Banks  
430 N. Salisbury Street  
Dobbs Bldg. Box 29512  
Raleigh, N.C. 27626-0512

*Statutory Authority G.S. 53-49; 53-92; 53-99.*

#### **.0807 SUBSIDIARY INVESTMENT APPROVAL**

Banks that desire to create or invest in a corporation, partnership, firm, joint venture or other ~~company~~ entity which will engage in a nonbanking function and which shall be either partially or wholly owned by the bank must first obtain the approval of the Commissioner of Banks. The application for approval shall be by letter which must include the following:

- (1) A copy of the articles of incorporation, articles of partnership or other instrument creating or governing the business entity;
- (2) A description of the proposed activities and by whom these activities will be conducted;
- (3) The proposed investment in the enterprise expressed both in dollar amount and as a percentage of the bank's unimpaired capital funds;
- (4) The amount of the bank's investment in all existing subsidiaries, partnerships and companies as of the date of the letter of application;
- (5) The amount of the bank's unimpaired capital fund on the date of the letter of application as the same is defined at G.S. 53-1(9);
- (6) A copy of any contract or agreement for a lease, rental or other commitment by the enterprise that would create a contingent liability upon the business (or enterprise) or the bank;
- (7) Copies of any licenses or other permits which the enterprise or its employees are required to obtain prior to engaging in a regulated activity. If such licenses are not available on the date of the letter of application the same must be submitted

- prior to final approval; and
- (8) The application fee as determined by NCAC 3C .1601(a)(8).

*Statutory Authority G.S. 53-47; 53-104.*

### **SECTION .0900 - OPERATIONS**

#### **.0901 BOOKS AND RECORDS**

Each bank, or its parent holding company, shall keep in permanent form, and available for examination by the representatives of the Commissioner of Banks, books and records which reflect all the transactions of the bank in its true financial condition. Such records shall be so kept as to permit and facilitate a speedy examination, which will, in turn, reflect such financial condition to the representatives of the Commissioner of Banks. Without implying that these are the only books and records to be kept, but, on the contrary, that these are necessary books and records, as well as other books and records usually kept, the following are required to be kept at the bank, or at its parent holding company, unless another storage site is approved by the Commissioner of Banks:

- (1) Each commercial bank or branch thereof in which notes or other forms of similar obligations are retained must keep an alphabetical liability ledger. The direct liability ledger must be kept in balance with the general ledger control. In a commercial bank whose automated record system is not able to produce an alphabetical liability ledger the bank must be able to produce an alphabetical listing of borrowers showing all of a customer's loan or customer account numbers and the amount outstanding under each number when called upon by the Commissioner of Banks or his duly authorized agent. In addition to the direct liability ledger, each commercial bank or branch thereof in which notes or other forms of similar obligations are retained must keep an alphabetical indirect liability ledger showing a customer's indirect obligations by loan name or account number and the balance outstanding under each account. Where the total of the direct and indirect lines do not exceed ~~ten thousand dollars (\$10,000)~~ twenty thousand dollars (\$20,000), the indirect line may be omitted from the indirect liability ledger. The indirect liability ledger must be updated at least monthly. Each



- commercial bank shall have the ability to produce both the direct and indirect liability ledgers in hard copy form upon call by the Commissioner of Banks or his duly authorized agent.
- (2) Records must be kept, showing the monthly reconciliation of each account with correspondent banks. A signed review of such reconciliations must be made by some officer or employee of the bank other than the person composing same.
  - (3) A permanent record must be kept of all stocks and bonds bought or sold. Also, there must be retained for review by examiners all original invoices of purchases and sales of securities. The record must show dates of purchases and sales, interest rates, maturities, par value, cost value, all write-ups or write-downs, a full description of the security, from whom purchased, to whom sold, selling price, and when, where and why pledged or deposited. This record must be maintained in balance with the general ledger control.
  - (4) A permanent record must be kept of all articles deposited for safekeeping. Receipts must be given and taken for all articles deposited or delivered. An inventory of parcels is not required.
  - (5) A permanent record must be kept of all items charged off. All charge-offs must be authorized or approved by the executive committee or by the board of directors and such action recorded in their minutes. This record, among other things, must show the date of the charge-off, a description of the asset and the amount. The record must be supported by the actual charged off items, or the final disposition of any item. In this record must also be recorded all recoveries, giving dates and amounts.
  - (6) A real estate record must be kept on all parcels owned, including the banking house. This record must show when, from whom, and how the property was acquired; date, cost price, book value, detailed income and detailed expenses. This record should be supported by appraisals, title certificates showing assessed value, tax receipts, and insurance policies.
  - (7) Proper minutes, showing clearly its action, must be kept for each committee, board of directors, board of managers, and stockholders' meetings. All minutes must be signed by the chairman and the secretary of this meeting.
  - (8) A permanent daily record must be kept of all cash items held over from the day's business, including all checks that would cause an overdraft if handled in the regular way. This record must show the name of the account on whom the item is drawn or is obligated for payment, the reason the item is being held, the date the item was placed in the cash items account, and the amount of the item. This record must be a daily record showing only those items held over at the end of each day's business and be kept in balance with the general ledger or control figure.
  - (9) A detailed record of income and expenses must be kept, balanced monthly, and a report thereof made to the executive committee or board of directors, and the receipt of same noted in their minutes.
  - (10) In the discretion of the Commissioner of Banks, he may require the preparation or maintenance of further books or records by specific banks or branches thereof.
  - (11) Each industrial bank, when preparing a report of condition and income, must include and make a part of this report a list of those whose obligations to the bank, whether the obligations are direct or indirect, and including paper purchased by the bank, are in excess of ten percent of capital, surplus and undivided profits. In lieu of this list, the bank must maintain a liability ledger in accordance with Subsection (1) of this Rule. Any commercial bank making installment loans may, with reference to such installment loans, make the report specified in this section in lieu of the liability ledger required under Subsection (1) of this Rule.

*Statutory Authority G.S. 53-92; 53-110.*

## **SECTION .1000 - LOAN ADMINISTRATION AND LEASING**

### **.1001 LOAN DOCUMENTATION**

~~Each bank or branch thereof where notes are~~

retained must have the following information:

- (1) ~~Current financial statements, dated within the preceding 18 months, and properly certified, must be on file from those directly liable to the bank in an amount of ten thousand dollars (\$10,000.00) or more, which obligations are unsecured, to the extent of ten thousand dollars (\$10,000.00), or secured only by endorsements. This applies, also, to the endorser where such endorsements are the basis of credit.~~
- (2) ~~This Subpart does not apply to loans secured by real property:~~
  - (a) ~~A written appraisal of all collateral to loans must be made by the executive committee or loan committee of the bank or branch, or other reliable persons familiar with the value of the collateral, and must be kept on file where the note is lodged. All appraisals must be renewed every 12 months, except as required in (2)(d) of this Rule.~~
  - (b) ~~The appraisal must include:~~
    - (i) ~~name of borrower;~~
    - (ii) ~~date made;~~
    - (iii) ~~value of collateral;~~
    - (iv) ~~signatures of at least two persons making the appraisal except as permitted in (2)(e) of this Rule;~~
    - (v) ~~brief description of collateral;~~
    - (vi) ~~amount of prior lien;~~
    - (vii) ~~original amount or outstanding balance of the loan.~~
  - (c) ~~No appraisal is required:~~
    - (i) ~~on collateral to notes of less than twenty thousand dollars (\$20,000.00);~~
    - (ii) ~~on loans fully secured by obligations of the United States or the State of North Carolina;~~
    - (iii) ~~on loans fully secured by deposits in the bank making the loan;~~
    - (iv) ~~on loans fully secured by the cash surrender or loan value of life insurance policies;~~
    - (v) ~~on loans fully secured by bonded warehouse receipts;~~
    - (vi) ~~on loans fully secured by listed securities, unless such loans are within the provisions of the Securities Exchange Act of 1934 as defined by Regulation "U," as amended, of the Board of Governors of the Federal Reserve System; On a loan of this~~

- type, an appraisal must be made and kept on file until the loan is paid;
- (vii) ~~on floor plan loans to dealers fully secured by new automobiles stationwagons, vans, and trucks;~~
- (viii) ~~on discounted notes for a dealer where the note is given as the purchase price of an automobile television set, washing machine, or property of a like character.~~
- (d) ~~Appraisals need not be renewed annually:~~
  - (i) ~~where an automobile, stationwagon or housetrailer is the sole collateral to a loan;~~
  - (ii) ~~where a truck or van not exceeding 8,000 pounds empty weight is the sole collateral to a loan.~~
- (e) ~~Appraisals may be signed by only one person:~~
  - (i) ~~where an automobile or stationwagon is the sole collateral to a loan;~~
  - (ii) ~~where a truck or van not exceeding 8,000 pounds empty weight is the sole collateral to a loan.~~
- (3) ~~All real estate given as security to loans of twenty thousand dollars (\$20,000.00) or over, whether directly or indirectly pledged, must be appraised either by two members of the executive or loan committee who are familiar with real estate values in the community where the property is located, or by two bank employees who are familiar with real estate values in the community where the property is located and who are not involved in the loan transaction secured by the property being appraised, or singularly by a State licensed real estate appraiser or State certified real estate appraiser or a person certified as a real estate appraiser by an appraisal trade organization. The person making an appraisal as provided by this Rule must be selected by the bank. The appraisal must be independent in that the appraiser is not involved in the loan transaction secured by the property being appraised and has no interest, financial or otherwise, in the property. The appraisal must be in writing, must be dated, must be signed as required in this Subparagraph by the person(s) making the appraisal, and be on file with the loan documents. The appraisal must state the~~



basis or approach used to determine the value of the property. A bank's appraisal form must identify the loan transaction for which the appraisal was made, the current balance of prior liens, if any, disclosed by the attorney's title certificate, segregate values of improvements from values of land, and describe the property so it may be easily identified. If a professional appraisal form is used which does not have all of the required information in this Subparagraph, the bank must complete and attach its own appraisal form, signed by one of its employees, to the outside appraisal report disclosing the required information.

- (4) For loans secured by real property, a certificate of title furnished by a competent attorney at law or title insurance issued by a company licensed by the Commissioner of Insurance must accompany each deed of trust or mortgage given as security on loans of twenty thousand dollars (\$20,000) or over. Provided that any loan which is based primarily on the borrower's general creditworthiness and projected income, whether or not accompanied by a deed of trust or mortgage, is not considered a loan secured by real property, and the first sentence of this Subparagraph shall not apply to any such loan.
- (5) Where stock certificates, or similar securities, are accepted as collateral to loans, each certificate must be endorsed and witnessed in ink, or accompanied by a stock power signed and witnessed in ink. Where such collateral is in the name of another, other than the maker or endorser of the note, there must be on file in the bank written authority from the owner permitting the hypothecation of the collateral.
- (6) Loans made directly to corporations must be supported by certified copies of resolutions of the board of directors of the corporation, authorizing the making of such loans.
- (7) Loans made directly to partnerships must be supported by a declaration by the partners showing the composition of the partnership and unless all partners sign the note, the authority of the partner(s)

executing the note to bind the partnership.

- (8) Full credit information on all unlisted securities, now owned or hereafter purchased or acquired, must be secured and kept on file in the bank.

Unless otherwise provided, each bank, or any branch thereof, where notes are held must maintain on file the appropriate supporting documents as follows:

- (1) Financial Statements. Financial statements shall be required from any borrower who is a maker, co-maker, guarantor, endorser or surety on any unsecured loans or other unsecured extensions of credit in an amount of twenty thousand dollars (\$20,000.00) or more in the aggregate. Financial statements required by this Item shall:
  - (a) be signed or otherwise properly executed;
  - (b) be dated within 18 months preceding the origination date of the credit obligation;
  - (c) be renewed within 18 months after the date of the last financial statement on file;
  - (d) be addressed to, or made specifically for, the lending bank; and
  - (e) include such information as will adequately reflect the assets, liabilities, net worth and income of the borrower.
- (2) Financial Statement Exceptions. A bank may waive the financial statement required by Item (1) of this Rule for credit granted under a credit card. Additionally, a bank may elect to substitute in the place of a current financial statement a current credit bureau report for consumer loans scheduled to be repaid in at least quarterly installments.
- (3) Personal Property Appraisals. Appraisals on personal property used as collateral for a loan shall be obtained and shall be completed as follows:
  - (a) Generally. Except as otherwise provided below, a written appraisal of personal property used to collateralize any loan must be made by the executive committee or loan committee of the bank, or any branch thereof, or other reliable persons familiar with the value of the property. Except as provided, all appraisals must be renewed every 12



- months.
- (b) Requirements. The appraisal required by this Item must include:
- (i) the name of the borrower;
  - (ii) the date the appraisal was made;
  - (iii) the value of the collateral;
  - (iv) the signatures of at least two persons making the appraisal;
  - (v) a brief description of the property;
  - (vi) the amount of any prior lien and holder of the lien, if any; and
  - (vii) the original amount or outstanding balance of the loan which the property is used to secure.
- (c) Appraisal Exceptions. No appraisal shall be required under the following circumstances:
- (i) on collateral to notes of less than twenty thousand dollars (\$20,000.00);
  - (ii) on loans fully secured by obligations of the United States or the State of North Carolina;
  - (iii) on loans fully secured by deposits in the bank maintaining the loan account;
  - (iv) on loans fully secured by the cash surrender or loan value of life insurance policies;
  - (v) on loans fully secured by bonded warehouse receipts;
  - (vi) on floor plan loans to dealers fully secured by new automobiles, stationwagons, vans, and trucks;
  - (vii) on discounted notes for a dealer where the note is given as the purchase price of an automobile or other consumer goods; or
  - (viii) on loans fully secured by listed securities, unless such loans are within the provisions of the Securities Exchange Act of 1934 as defined by Regulation "U," as amended from time to time by the Board of Governors of the Federal Reserve System. On loans secured by such collateral, appraisal must be made and kept on file until the loan is fully paid.
- (d) Renewal Exceptions. Appraisals need not be renewed annually where an automobile, stationwagon, mobile home, or where a truck or van not exceeding 8,000 pounds empty weight, is the sole or partial collateral for a loan.
- (e) Single Signature Exception. An appraisal may be signed by only one person where an automobile stationwagon, mobile home, or where a truck or van not exceeding 8,000 pounds empty weight, is the sole collateral for a loan.
- (4) Real Estate Appraisals. Unless otherwise provided, all real estate taken as security for loans shall be appraised in the form and manner set forth in Sub-item (4)(a) through (4)(c) of this Rule. In addition, the appraisal must be independent in that the appraiser is not involved in the loan transaction secured by the property being appraised and has no interest, financial or otherwise, in the property.
- (a) The bank may elect to waive the requirement for an appraisal of real estate given as security for loans of twenty thousand dollars (\$20,000.00) or less. Appraisals of real estate given as security for loans over twenty thousand dollars (\$20,000.00), but not exceeding two hundred fifty thousand dollars (\$250,000.00), whether directly or indirectly pledged shall be prepared by any one of the following methods:
- (i) Two members of the executive or loan committee who are familiar with real estate values in the community where the property is located.
  - (ii) Two bank employees who are familiar with real estate values in the community where the property is located, provided that one of the two employees must not be involved in the loan transaction secured by the property being appraised.
  - (iii) A state-licensed real estate appraiser or state-certified real estate appraiser or a person certified as a real estate appraiser by an appraisal trade organization approved by the bank to perform the appraisal.
  - (iv) In lieu of an appraisal as provided by Sub-items (4)(a)(i) through (iii) of this Rule, a bank may elect to accept a bona fide copy of the most recent real property tax notice from the tax administrator's office in the county in which the property is located provided that such notice states the assessed ad valorem tax value of the real estate and any improvements thereon.

separate from the personal property; and provided further, the loan officer shall include with the tax notice a memorandum to file that he or she has obtained the notice from the county tax administrator and is of the opinion that such notice accurately reflects the real property values.

- (b) Except as noted, appraisals required by Sub-item (4)(a) of this Rule shall be in writing, and signed and dated by the person or persons making the appraisal. Additionally, the appraisal must identify the loan transaction for which it was made, the current balance of prior lien and holder of the lien, if any, disclosed by the attorney's title certificate, segregate values of improvements from values of the land, and describe the property so as to make it easily identifiable. If a professional appraisal form is used which does not include this information, the bank must complete and attach to such appraisal its own appraisal form disclosing the required information. The appraisal must state the basis or approach used to determine the value of the property. Acceptable approaches to determining the value of real property are:

- (i) The current cost of replacing a property, less depreciation relating to deterioration in functional and economic obsolescence.
- (ii) The value indicated by recent sales of comparable properties in the market and other market factors such as listings and offers to sell.
- (iii) The value that the property's net earning power will support, based on a capitalization of net income.

- (c) All real estate given as security to loans in an amount over two hundred fifty thousand dollars (\$250,000.00), whether directly or indirectly pledged shall be appraised and such appraisal shall be subject to the provisions of 12 C.F.R. 321.1 through 12 C.F.R. 323.7, which are herein incorporated by reference. Pursuant to G.S. 150B-21.6, any reference to 12 C.F.R. 323.1 through 12 C.F.R. 323.7 shall automatically include any later amendments or additions to those rules.

- (5) Certificate of Title. For loans secured by

real property, a certificate of title furnished by a competent attorney at law or, title insurance issued by a company licensed by the Commissioner of Insurance, must accompany each deed of trust or mortgage given as security on loans of twenty thousand dollars (\$20,000.00) or more.

- (6) Stock Certificate/Powers. Where stock certificates, or similar securities, are accepted as collateral to loans, each certificate must be endorsed and witnessed in ink, or accompanied by a stock power signed and witnessed in ink. Where such collateral is in the name of another, other than the maker or endorser of the note, there must be on file in the bank written authority from the owner permitting the hypothecation of the collateral.

- (7) Corporate Resolutions. Loans made directly to corporations must be supported by certified copies of resolutions of the board of directors of the corporation, authorizing the making of such loans.

- (8) Partnership Declaration. Loans made directly to partnerships must be supported by a declaration by the partners showing the composition of the partnership and unless all partners sign the note, the authority of the partner(s) executing the note to bind the partnership.

- (9) Unlisted Securities. Full credit information on all unlisted securities, now owned or hereafter purchased or acquired, must be secured and kept on file in the bank.

*Statutory Authority G.S. 53-92; 53-110.*

## SECTION .1100 - CAPITAL

### .1101 DEFINITIONS; ISSUANCE OF CAPITAL NOTES AND DEBENTURES

~~A bank may issue long term (capital) debentures and notes only after having first received the written approval of the Commissioner of Banks.~~

For the purposes of this Section, the following definitions shall apply:

- (1) Capital Note. Any unsecured note or debenture issued by a bank that qualifies as capital pursuant to the provisions of G.S. 53-1(9).



- (2) Convertible Debentures. A debenture which is convertible into the capital stock of the issuing bank.
- (3) Debenture. An unsecured promise to pay issued under the terms of a deed of trust or indenture.
- (4) Long-Term Note or Debentures. Any note or debenture having a maturity of more than seven years.
- (5) Medium-Term Note or Debentures. Any note or debenture having a maturity of not less than one or more than seven years.
- (6) Non-convertible Debentures. A debenture which may not be converted into the shares of the capital stock of the issuing bank.
- (7) Subordinated debentures. Debentures which are subordinated to and junior in right of payment to a banker's obligations to its depositors, its obligations under banker's acceptances and letters of credit, its obligations to any Federal Reserve Bank and any similar obligations to its other creditors, which, in the event of insolvency, receivership, conservatorship, reorganization, readjustment of debt, marshalling of assets and liabilities or like proceedings, or in any liquidation or winding up of or relating to the bank, whether voluntary or involuntary, shall be entitled to be paid in full before any amount shall be made on account of the principal of, or premium, if any, or interest on the debentures or notes.
- (8) Unsubordinated Debentures. A bank may issue medium term or long term capital notes and debentures only after having first received the written approval of the Commissioner of Banks.

Statutory Authority G.S. 53-43.4; 53-92; 53-104.

## SECTION .1300 - BANK PERSONNEL

### .1301 ANNUAL VACATION

(a) Every bank or branch thereof, under the supervision of the Commissioner of Banks, must grant to each officer and employee an annual vacation period of at least six five working days. The annual vacation period must be granted on consecutive working days and each officer and employee must remain absent from his duties continuously throughout the vacation period. Provided, however, that any bank or branch that

remains closed on Saturdays and Sundays must grant to each officer and employee an annual vacation of at least five consecutive working days. This Rule shall not apply to any specific individual, officer or employee or group or class of officers or employees, upon application by any bank or branch thereof and with the approval of the Commissioner of Banks.

(b) This Regulation does not apply to those officers and employees who have been in a bank's employment for a period of less than one year. Neither does this Regulation apply to employees of a bank's incorporated subsidiary when the employee does not perform any banking service or duties for the parent bank.

Statutory Authority G.S. 53-92; 53-104.

### .1302 SHARE PURCHASE AND OPTION PLANS

A state chartered bank may establish:

- (1) ~~stock option plans for the benefit of its directors, officers, employees, or any of these groups, and~~
- (2) ~~stock purchase plans for the benefit of officers and employees provided the following conditions are met:~~
  - (a) ~~The bank must submit a written request to the Commissioner which includes or incorporates by reference the following information:~~
    - (i) ~~A draft of the plan document,~~
    - (ii) ~~A copy of the proposed notice of shareholders' meeting, proxy, and proxy statement,~~
    - (iii) ~~The number of authorized but unissued shares that will be allocated to the plan,~~
    - (iv) ~~A copy of any proposed amendments to the Articles of Incorporation creating authorized but unissued stock and eliminating pre-emptive rights as to shares reserved under a stock option or stock purchase plan, and~~
    - (v) ~~The number of shares of stock outstanding at the time the request is made and the number of shares which have previously been allocated to any stock option or stock purchase plan.~~
  - (b) ~~Except for stock option plans for directors, the plan is administered by a committee, none of whose members may participate in the plan.~~
  - (c) ~~The number of shares allocable to any person under the plan is reasonable in~~



~~relation to the purpose of the plan and the needs of the bank.~~

- ~~(d) In the case of a stock option plan, the number of shares subject to the plan is reasonable in relation to the bank's capital structure and anticipated growth.~~
- ~~(e) Shares issued to employees and officers under this Regulation may be authorized but unissued stock which has been authorized by stockholders in accordance with state law, and in accordance with proper notification of shareholders.~~
- ~~(f) Stock allocated or reserved for a stock option plan or a stock purchase plan may not be included in computing the bank's investment limitation, loan limitation, fixed asset limitation, or any other limitation based on capital, until the stock has been paid for in full.~~

(a) Officer and employee plans. A bank may establish a stock option or stock purchase plan for the benefit of its officers and employees, or any of these groups, provided that, in addition to the required approval of shareholders, the following conditions are met:

- (1) The plan shall be in writing.
- (2) The plan shall be administered by a committee from the board of directors, none of whose members, may participate in the same.
- (3) In the case of a stock option plan, the number of shares subject to the plan is reasonable in relation to the bank's capital structure and anticipated growth. For the purposes of this Subparagraph, any plan to which there is allocated no more than 10% of the total of the bank's outstanding shares and the shares reserved for the plan, will be deemed reasonable in reaction to the bank's capital structure and anticipated growth.
- (4) The number of shares which may be allocated to any person under a plan is reasonable in relation to the purpose of the plan and the needs of the bank. For the purposes of this Subparagraph, any plan which provides that no more than 40% of the shares which have been set aside for option may be allocated to any one participant will be deemed reasonable in relation to the purpose of the plan and needs of the bank.

(b) Directors stock option plans. A bank may

establish a stock option plan for the benefit of its directors provided that the following conditions are met:

- (1) The plan shall be in writing.
- (2) The number of shares allocated to the plan is reasonable in relation to the bank's capital structure and anticipated growth. For the purposes of this Subparagraph, any plan to which there is allocated no more than 10% of the bank's outstanding shares and the shares reserved for the plan will be deemed reasonable in relation to the bank's capital structure and anticipated growth.
- (3) The number of shares allocable to any person under the plan is reasonable in relation to the purpose of the plan and the needs of the bank. For the purposes of this Subparagraph, any plan which provides that no more than 40% of the shares which have been set aside for option may be allocated to any one participant will be deemed reasonable in relation to the purpose of the plan and the needs of the bank.

(c) Shares issued to employees, officers and directors under this Rule may be authorized but unissued stock which has been authorized by stockholders in accordance with state law and in accordance with proper notification of shareholders.

(d) Stock allocated or reserved for a stock option plan or a stock purchase plan may not be included in computing the bank's investment limitation, loan limitation, fixed asset limitation, or any other limitation based on capital, until the stock has been paid for in full.

(e) Approval. Before a bank may establish any plan set forth in Paragraphs (a) and (b) of this Rule, it shall submit a written request to the Commissioner which includes or incorporates by reference the following information:

- (1) A draft of the proposed plan document;
- (2) A copy of the proposed notice of shareholders' meeting, proxy, and proxy statement;
- (3) The number of authorized but unissued shares that will be allocated to the plan;
- (4) A copy of any proposed amendments to the Articles of Incorporation creating authorized but unissued stock and eliminating pre-emptive rights as to shares reserved under a stock option or stock purchase plan; and

- (5) The number of shares of stock outstanding at the time the request is made and the number of shares which have previously been allocated to any stock option or stock purchase plan.

Provided that a proposed plan complies with the applicable conditions of Paragraph (a) or (b) of this Rule, it will be approved subject to the required vote of shareholders and submission of a final plan document, final approval will be given by the Commissioner of Banks.

(f) Maximum limitation. Notwithstanding any of the provisions of this Section, a bank shall not:

- (1) Allocate in the aggregate more than 20% of its outstanding shares to stock purchase plans; nor,
- (2) Allocate to any one participant more than 40% in the aggregate of all the shares reserved for option.

Statutory Authority G.S. 53-10; 53-43; 53-43.3; 53-92; 53-104.

## SECTION .1700 - NONRESIDENT BANKS

### .1701 DEFINITIONS

For the purposes of this Section, the following definitions shall apply:

- (1) Loan Production Office. A loan production office (hereinafter "LPO") is defined as an office in North Carolina of a nonresident bank established solely for the purposes of soliciting loans.
- (2) Lockbox Service. A lockbox service is an arrangement by which a nonresident bank uses a designated post office box and a remittance processing center to timely receive and collect payments due customers of the bank.
- (3) Trust Representative Office. A trust representative office (hereinafter "TRO") is defined as an office in North Carolina of a nonresident trust company or bank exercising trust powers established for the purpose of soliciting new fiduciary accounts for the nonresident trust company or bank and providing information to and facilitating communications with its customers in North Carolina.
- (4) Business Development Office. A business development office (hereinafter "BDO") is an office in North Carolina of a nonresident bank established solely for the purpose of representing the principal

office of a nonresident bank in soliciting loan, investments, and other business within this state.

Statutory Authority G.S. 53-104; 53-115; 53-127.

### .1702 ESTABLISHMENT OF LPO's

A nonresident bank may establish an LPO in North Carolina under written agreement with the Commissioner which provides that:

- (1) The LPO may be used to solicit loans assemble credit information, make property inspections and appraisals, complete loan applications, and perform other preliminary paper work in preparation for the making of loans;
- (2) Loans may not be approved nor or loan proceeds disbursed through the LPO;
- (3) The LPO may not be used to solicit or accept deposits;
- (4) The LPO may be inspected by the Commissioner of Banks for compliance with the written agreement, the cost of which inspection shall be borne by the nonresident bank;
- (5) The nonresident bank will complete and keep current a Loan Production Office Registration with the Commissioner of Banks; and
- (6) If required by the Secretary of State, the LPO will obtain a certificate of authority to do business in North Carolina.

Statutory Authority G.S. 53-104; 53-115; 53-127.

### .1703 ESTABLISHMENT OF LOCKBOX SERVICES

(a) Generally. A nonresident bank may establish a lockbox service within North Carolina through a subsidiary service corporation of the bank or parent bank holding company provided the following criteria are met:

- (1) The nonresident bank must first notify the Commissioner of Banks in writing of their intent to operate such a service; and
- (2) Such banks must disclose to the Commissioner the proposed location of the remittance processing center and the designated manager of the same.

(b) Permissible Activity. A lockbox service may collect remittances daily from designated post office boxes and process them for deposit in a North Carolina bank for the benefit of the lockbox customer. The customer may repossess its funds



deposited in the North Carolina bank at any time while these funds remain in such accounts, or the customer may transmit or arrange for the transmission of its funds deposited in the North Carolina bank to a location it so designates.

(c) Annual Report. Nonresident banks operating lockbox services in North Carolina must report annually in writing to the Commissioner summarizing its operations in North Carolina. Any additional services or changes in services must be consistent with North Carolina banking laws and regulations.

Statutory Authority G.S. 53-104; 53-127.

#### 1704 ESTABLISHMENT OF TRO's

(a) A nonresident trust company or bank exercising trust powers may establish a TRO in North Carolina under written agreement with the Commissioner which provides that:

- (1) The TRO may be used to solicit new fiduciary accounts, assemble customer information, prepare applications and other forms, transfer documents from customers to the nonresident trust company or bank, provide information to customers about their accounts, and generally respond to inquiries;
- (2) Fiduciary accounts may not be approved nor accepted through the TRO;
- (3) The TRO may not be used to solicit or accept deposits;
- (4) The TRO may be inspected by the Commissioner for compliance with the written agreement, the cost of which inspection shall be borne by the nonresident trust company or bank;
- (5) The nonresident trust company or bank will complete and keep current a Trust Representative Office Registration with the Commissioner of Banks; and
- (6) If required by the Secretary of State, the TRO will obtain a Certificate of Authority to do business in North Carolina.

(b) Before operating a TRO in North Carolina, a nonresident trust company or bank, in addition to complying with Paragraph (a) of this Rule, shall complete a TRO Registration which provides the following information:

- (1) The name of the nonresident trust company or bank;
- (2) The business address of the nonresident trust company's or bank's corporate

office;

- (3) The state in which the nonresident trust company or bank is chartered, or if federally chartered, the state in which the nonresident trust company or bank is authorized to engage in a banking and trust business;
- (4) If the nonresident trust company or bank is a subsidiary of a bank holding company, the name of such holding company and the state in which the same is incorporated;
- (5) The business location of the North Carolina TRO and the mailing address, if different;
- (6) The telephone number of the North Carolina TRO;
- (7) The person in charge of the North Carolina TRO;
- (8) The number of people who will be present soliciting fiduciary accounts in North Carolina; and
- (9) If required to be registered as a foreign corporation by the Secretary of State, the name and address of the North Carolina agent for service of process.

Statutory Authority G.S. 53-104; 53-115; 53-127.

#### 1705 ESTABLISHMENT OF BDO'S

(a) A nonresident bank may establish a BDO in North Carolina under written agreement with the Commissioner which provides that:

- (1) The BDO may be used to develop business relationships within North Carolina, solicit loans, credit cards, investments, and other business within North Carolina;
- (2) The BDO shall be staffed by resident representatives;
- (3) The BDO may not approve or have any authority to approve loans;
- (4) The BDO may not disburse loan proceeds or any other money to any borrower. Funding for all North Carolina loans will be provided by the principal office of the nonresident bank to the borrower or the borrower's account, borrower's agent or to an escrow agent;
- (5) The BDO may not solicit or accept money for deposit in North Carolina, nor issue checks in North Carolina;
- (6) The BDO may not maintain customer accounts in North Carolina for deposit



or withdrawal nor will it advertise or represent that it will offer such services;

- (7) The BDO may not collect loan payments. Loan payments shall be made directly to its principal office;
- (8) The BDO may be inspected by the Commissioner of Banks for compliance with the written agreement, the cost of which shall be borne by the nonresident bank;
- (9) The nonresident bank shall complete and keep current a Business Development Office Registration with the Commissioner of Banks; and
- (10) If required by the Secretary of State, the BDO will obtain a certificate of authority to do business in North Carolina.

(b) Before operating a BDO in North Carolina, a nonresident bank, in addition to complying with Paragraph (a) of this Rule, shall complete a BDO Registration which provides the following information:

- (1) The name of the nonresident bank;
- (2) The business address of the nonresident bank's corporate offices;
- (3) The state in which the nonresident bank is chartered, or if federally chartered, the state in which the nonresident bank is authorized to engage in a banking business;
- (4) If the bank is a subsidiary of a bank holding company, the name of such holding company and the state in which the same is incorporated;
- (5) The business location of the North Carolina BDO and the mailing address, if different;
- (6) The telephone number of the North Carolina BDO;
- (7) The person in charge of the North Carolina BDO;
- (8) The number of people who will be present and developing business relationships and soliciting loans and other business in North Carolina; and
- (9) If required to be registered as a foreign corporation by the Secretary of State, the name and address of the North Carolina agent for service of process.

*Statutory Authority G.S. 53-104; 53-115; 53-127.*

## SECTION .1800 - COURIER SERVICE

## .1801 ESTABLISHMENT OF COURIER SERVICES

(a) Generally. A state bank may provide courier or messenger service to its customer provided that a written agreement between the bank and the customers contains the items in Paragraph (b) of this Rule.

(b) The written agreement referred to in Paragraph (a) of this Rule must contain the following:

- (1) A statement that the courier is the agent of the customer and not the agent of the bank.
- (2) A statement that deposits collected by the courier or messenger are received by the bank when the deposits have actually been delivered to a teller at the bank's premises.
- (3) A statement which indicates that negotiable instruments collected by the courier or messenger are paid at the bank when delivered to the courier or messenger.

*Statutory Authority G.S. 53-43; 53-104; 53-115.*

## .1802 COMPLIANCE AND DISCLOSURE REQUIREMENTS

(a) A state bank shall disclose to its customer that transactions conducted by a courier service are in no way insured by the FDIC.

(b) A state bank must also comply with requirements imposed by the Private Protective Service Act, N.C. G.S. 74(c)-1 et. seq.

*Statutory Authority G.S. 53-43; 53-104; 53-115.*

## TITLE 10 - DEPARTMENT OF HUMAN RESOURCES

*Notice is hereby given in accordance with G.S. 150B-21.2 that the N.C. Medical Care Commission intends to adopt rules cited as 10 NCAC 3C .3001 - .3101, .3201 - .3205, .3301 - .3303, .3401 - .3405, .3501 - .3503, .3601 - .3609, .3701 - .3708, .3801 - .3804, .3901 - .3907, .4001 - .4005, .4101 - .4110, .4201 - .4204, .4301 - .4308, .4401 - .4403, .4501 - .4516, .4601 - .4605, .4701 - .4705, .4801 - .4806, .4901 - .4907, .5001 - .5005, .5101 - .5105, .5201 - .5207, .5301 - .5327, .5401 - .5408, .5501 - .5514, .6001 - .6002, .6101 - .6104, .6201 - .6227; repeal .0101 - .0102, .0104 - .0110, .0201 - .0203, .0301 - .0307, .0401 - .0407, .0501 - .0505, .0601 - .0604, .0701 - .0708, .0801 - .0805, .0807, .0901*

.0917, .1001 - .1006, .1101 - .1102, .1201 - .1204, .1301 - .1303, .1401 - .1405, .1501 - .1508, .1510, .1601 - .1606, .1701 - .1717, .1801 - .1805, .1901 - .1912, .1915 - .1932, .2001 - .2008, .2020 - .2033 and .2101 - .2105.

The proposed effective date of this action is May 1, 1995.

The public hearing will be conducted at 9:30 a.m. on March 10, 1995 at the Council Building, 701 Barbour Drive, Room 201, Raleigh, NC, 27603.

Reason for Proposed Action: To revise and modernize the Hospital Licensure Rules.

Comment Procedures: In order to allow the Commission sufficient time to review and evaluate your written comments prior to the hearing, please submit your comments to Mr. Jackie Sheppard, IPA Coordinator, DFS, P.O. Box 29530, Raleigh, NC 27626-0530, telephone (919) 733-2342 by March 3, 1995, but in no case later than the hearing on March 10, 1995.

## CHAPTER 3 - FACILITY SERVICES

### SUBCHAPTER 3C - LICENSING OF HOSPITALS

#### SECTION .0100 - PROCEDURE

##### .0101 GENERAL CONFERENCE

No plans to establish a hospital shall be undertaken until those responsible for planning have visited the Division of Facility Services for a general conference in which elements peculiar to hospital construction can be broadly explained.

Statutory Authority G.S. 131E-79.

##### .0102 REVIEW

All stages of the plans from schematics through working drawings shall be reviewed by the Division's staff at each time a change is made.

Statutory Authority G.S. 131E-79.

##### .0104 APPROVAL

Approval of plans by the Division of Facility Services, the Division of Health Services, and

Department of Insurance shall be obtained before construction or renovation is commenced.

Statutory Authority G.S. 131E-79.

#### .0105 APPLICATION

(a) Prior to admission of patients, an application for a license shall be submitted to the Division of Facility Services.

(b) Forms may be obtained by contacting the Division of Facility Services.

(c) The application shall set forth the ownership, staffing patterns, medical services to be rendered, professional staff in charge of primary services, the maximum bed capacity and general information that would be helpful to the Division in knowing fully of the hospital's operating program.

Statutory Authority G.S. 131E-77.

#### .0106 CERTIFICATE

When the hospital building has met construction requirements, a bed capacity has been established and approved in accordance with Section 1500 of this Subchapter, and application for license has been approved, then a certificate of licensure shall be issued in accordance with classification designations as set forth in Rule .0202 of this Subchapter.

Statutory Authority G.S. 131E-77.

#### .0107 LENGTH OF LICENSE

A license, unless specified for a lesser period, is effective for the year ending December 31.

Statutory Authority G.S. 131E-77.

#### .0108 RENEWAL

(a) Each license must be renewed at the beginning of the calendar year.

(b) Renewal is accomplished by the completion by the hospital of a reapplication form which is sent to the hospital in the late fall.

Statutory Authority G.S. 131E-77.

#### .0109 LICENSURE SURVEYS

(a) Prior to the initial issuance of a license to operate a hospital, the Division will conduct a survey to determine compliance with regulations promulgated pursuant to G.S. 131E-79.

(b) When considered necessary, the Division may conduct an investigation of a specific complaint in any licensed hospital.

(c) Hospitals that are accredited by the Joint

~~Commission on Accreditation of Healthcare Organizations (JCAHO) shall choose one of the following options:~~

- ~~(1) Accredited hospitals may agree to provide the Division with:~~
  - ~~(A) JCAHO Accreditation Certificate;~~
  - ~~(B) JCAHO Statement of Construction;~~
  - ~~(C) J C A H O R e p o r t s a n d Recommendations;~~
  - ~~(D) JCAHO Interim Self Survey Reports, and~~
  - ~~(E) permission to participate in any regular survey conducted by the JCAH.~~

~~If a review of the information listed in Subparagraphs (c) (1) (A) (c) (1) (D) indicates deficiencies with or exceptions to licensure regulations contained in this Subchapter, then the Division may conduct surveys or partial surveys with special emphasis on deficiencies noted. If a review indicates compliance with licensure regulations contained in this Subchapter, the Division will not conduct a licensure survey except as provided in (b), (C) (1) (E), and (d) of this Rule.~~

- ~~(2) Accredited hospitals which do not agree to provide the Division with JCAH reports found in (c) (1) of this Rule may be surveyed annually but will be surveyed by the Division at least once every two years.~~

~~(d) The Division reserves the right to conduct any validation survey in hospitals that choose the option under (c) (1) of this Rule.~~

~~(e) The Division may survey non accredited hospitals annually but will survey these hospitals at least every two years.~~

*Statutory Authority G.S. 131E-79.*

#### .0110 ITEMIZED CHARGES

~~(a) The facility shall either present an itemized list of charges to all discharged patients or the facility shall include on patients' bills which are not itemized notification of the right to request an itemized bill within 30 days of receipt of the non-itemized bill.~~

~~(b) If requested, the facility shall present an itemized list of charges to each patient, or his responsible party.~~

~~(c) The itemized listing shall include, at a minimum, those charges incurred in the following service areas:~~

- ~~(1) Room rates;~~
- ~~(2) Laboratory;~~
- ~~(3) Radiology and Nuclear Medicine;~~
- ~~(4) Surgery;~~
- ~~(5) Anesthesiology;~~
- ~~(6) Pharmacy;~~
- ~~(7) Emergency and ambulatory services;~~
- ~~(8) Specialized Care;~~
- ~~(9) Extended Care;~~
- ~~(10) Prosthetic and Orthopedic appliances;~~
- ~~(11) Other professional services.~~

~~(d) The facility shall indicate on the initial or renewal license application that patient bills are itemized, or that each patient or responsible party is formally advised of the patient's right to request an itemized listing within 30 days of receipt of non-itemized bill.~~

*Statutory Authority G.S. 131E-91.*

### SECTION .0200 - GENERAL

#### .0201 CLASSIFICATION OF MEDICAL FACILITIES

~~(a) The classification of "hospital" shall be restricted to facilities that provide as their primary functions diagnostic services and intensive medical and nursing care in the treatment of acute stages of illness. On the basis of specialized facilities and services available, each such hospital will be licensed as to the following medical types;~~

- ~~(1) general acute care hospital;~~
- ~~(2) rehabilitation hospital;~~
- ~~(3) designated primary care hospital;~~
- ~~(4) federally certified primary care hospital.~~

~~(b) All other inpatient medical facilities accepting patients requiring skilled nursing services but which are not operated as a part of any hospital within the above meaning shall be considered to be operating as a nursing home and therefore are not subject to hospital licensure.~~

~~(c) Each hospital applying for licensure will be classified in accordance with the determination of the Division of Facility Services.~~

*Statutory Authority G.S. 131E-76; 131E-79.*

#### .0202 TYPES OF LICENSES

~~Each hospital license issued shall indicate thereon whether it is a class I, class II, or temporary conditional hospital license in accordance with the following provisions:~~

- ~~(1) Hospital licenses, class I, will be issued to new or existing hospitals that comply~~



with requirements of the construction standards established in the State Building Code and the rules and regulations of the Division of Facility Services;

- (2) ~~Hospital licenses, class II, will be issued to existing hospitals that do not comply with the construction standards established in the State Building Code but have completed measures recommended by the State Insurance Department to provide occupants with a minimum of safety which can be afforded by compliance with such recommendations and otherwise meet the requirements of the Division of Facility Services;~~
- (3) ~~Temporary conditional hospital license will be issued to hospitals that do not fully meet requirements of the construction standards established in the State Building Code and have not completed measures recommended by the State Insurance Department to provide a minimum of safety, or do not meet other requirements of the Division of Facility Services, but which agree to correct specified deficiencies within the time period prescribed by the Division.~~

Statutory Authority G.S. 131E-79.

## 203 CONSTRUCTION

(a) ~~Standards. The design and construction shall be in accordance with the construction standard of the North Carolina Division of Facility Services, the North Carolina Building Code, and local municipal codes.~~

(b) ~~Plans. Submission of plans:~~

- (1) ~~Before construction is begun, plans and specifications covering construction of the new buildings, alterations or additions to existing buildings, or any change in facilities must be submitted to the Division for approval;~~
- (2) ~~Thereupon, the Division will review the plans and notify the licensee that said buildings, alterations, additions, or changes are approved or disapproved with such recommendations as the Division will care to make;~~
- (3) ~~In order to avoid unnecessary expense in changing final plans, it is suggested that as a preliminary step, proposed plans in sketch form be reviewed with the Division;~~
- (4) ~~The plans shall include a plot plan~~

~~showing the size and shape of the entire site and the location of all existing and proposed facilities;~~

- (5) ~~Plans shall be submitted in triplicate in order that the Division may distribute a copy to the State Insurance Department for review under State Building Code requirements and to the Division of Health Services for review under state sanitation requirements.~~

(e) ~~Location~~

- (1) ~~The site for new construction or expansion must have the approval of the Division;~~
- (2) ~~Hospitals should be so located that they are free from undue noise from railroads, freight yards, main traffic arteries, schools and children's playgrounds;~~
- (3) ~~The site should not be exposed to smoke, foul odors, or dust from nearby industrial plants;~~
- (4) ~~The area of the site should be sufficient to permit future expansion and to provide adequate parking facilities;~~
- (5) ~~The site should be easily accessible to patients, doctors, and employees;~~
- (6) ~~Available paved roads, adequate water, sewage, and power lines should be taken into consideration in selecting the site.~~

Statutory Authority G.S. 131E-79.

## SECTION .0300 - ADMINISTRATION

### .0301 GOVERNING BOARD

(a) ~~The governing board, or owner, or the person or persons designated by the owner as the governing authority shall be responsible for seeing that the objectives specified in the charter (or resolution if publicly owned) are attained.~~

(b) ~~The governing board shall be the supreme authority in the hospital to which the administrator, the medical staff, the personnel, and all auxiliary organizations are directly or indirectly responsible.~~

(c) ~~The governing board shall be responsible for the formulation or approval of such bylaws as may be desirable for the proper operation of the hospital.~~

(d) ~~The board shall conduct regular meetings and may appoint officers and committees in carrying out its functions.~~

(e) ~~The board shall select and appoint a~~

competent administrator and delegate to him executive authority and responsibility.

(f) The board shall appoint a competent medical staff composed of an adequate number of physicians whom it deems qualified after a formal review of their respective credentials.

(g) The governing board shall encourage the administrator and the medical staff to qualify the hospital to meet the standards of the Joint Commission on Accreditation of Hospitals.

(h) A hospital with one or more units, or portions of units, however described, utilized for psychiatric or substance abuse treatment shall adopt policies implementing the provisions of North Carolina General Statutes Chapter 122C Article 3 and Article 5 parts 2, 3, 4, 5, 7, and 8.

*Statutory Authority G.S. 131E-79.*

### .0302 ADMINISTRATOR

(a) There shall be a competent executive officer or administrator with authority and responsibility for the operation of the hospital in all its administrative and professional functions, subject only to the policies enacted by the governing board and to such orders as it may issue.

(b) The administrator shall be the direct representative of the governing authority in the management of the hospital and shall be responsible to said board alone for the proper performance of his duties.

(c) The administrator shall provide liaison between the governing body, the medical staff, the nursing staff, and other departments of the hospital.

(d) The administrator shall advise the governing board in the formulation of hospital policies.

(e) It is recommended that the administrator prepare a manual of hospital policies and procedures for use by employees and medical staff to assist in understanding their responsibilities within the organization of the hospital.

*Statutory Authority G.S. 131E-79.*

### .0303 ACCOUNTING

(a) Within business hours, the financial and statistical records of the hospital shall be available for inspection at all times by the Division of Facility Services through its duly authorized representatives.

(b) Accounting procedures should be carried out in accordance with a recognized system of hospital accounting and should be adequate to permit satisfactory auditing.

(c) It is recommended that an audit be performed at least annually by a qualified auditor who is not a regular employee of the hospital.

*Statutory Authority G.S. 131E-79.*

### .0304 TELEPHONES

There should be at least one telephone on each floor with provisions for calling outside the hospital building(s) and additional telephones or extensions as required for proper internal communications and for summoning help promptly in case of fire or other emergency.

*Statutory Authority G.S. 131E-79.*

### .0305 ADMISSION AND DISCHARGE

(a) The hospital administration shall provide the admitting office with written admission and discharge policies which reflect the established purposes of the hospital and the intent of its governing board.

(b) There shall be on the premises at all times an employee authorized to receive patients and to make administrative decisions on their disposition.

(c) A patient shall be admitted only under the care of a physician meeting the provisions of Rule .0404 of this Subchapter.

(d) Reasonable precautions shall be taken to ensure the safety and legal rights of all patients.

(e) A complete and permanent record shall be maintained for all outpatients and inpatients including the date and time of admission and discharge. A reasonable effort shall be made to verify the full and true name, address, date of birth, nearest of kin, provisional diagnosis, condition on admission and discharge, referring physicians, attending physician or service.

(f) All patients shall be provided at the time of their admission with an identification bracelet, band, or other suitable device for positive identification.

(g) No mentally competent adult shall be detained in the institution against his will, nor shall a child be detained against the will of a parent or legal guardian. This restriction shall not apply to persuasion of the patient in his own interest to consider the possible consequences of his actions, nor to the temporary detention of a mentally disturbed patient for the protection of himself and others, pending prompt legal disposition as may be provided for in G.S. 122C which is hereby adopted by reference pursuant to G.S. 150B 14(e). Documentation of the commitment process shall be retained for all involuntary commitments in



accordance with the provisions of Rule 10 NCAC 3C .1405.

(h) An infant or child shall be discharged only to the custody of its parent, legal guardian, or custodian. Exception to this can be made to a member of the immediate family or friend having the parents' validated consent according to hospital procedure.

Statutory Authority G.S. 131E-79.

### 0306 RECORDS AND REPORTS

(a) The following essential documents and references shall be on file in the administrative offices of the hospital:

- (1) certificate of incorporation (if incorporated);
- (2) bylaws of the governing authority (if applicable);
- (3) bylaws of the medical staff;
- (4) minutes of the governing authority (if applicable);
- (5) minutes of the medical staff and staff committees;
- (6) applications of all current members of the medical staff, professional and technical personnel containing qualifications and supporting information documenting conformity with requisite professional licensing laws, action by staff committees, and the governing authority;
- (7) insurance policies, mortgages, deeds and other contracts (or true copies) to which the hospital is a party;
- (8) rules and recommendations of the Division of Facility Services regulating the operation of hospitals;
- (9) report of the most recent inspection by the Joint Commission on Accreditation of Hospitals (if applicable);
- (10) necessary licenses, permits, and certificates for the hospital, and for certain staff personnel, as required.

(b) Each hospital shall submit reports containing such pertinent data as required by the Division of Facility Services.

(c) Institutions licensed under these standards must fully comply with the rules and regulations promulgated by the North Carolina Division of Health Services relating to vital statistics.

Statutory Authority G.S. 131E-79.

### 0307 RISK MANAGEMENT

Pursuant to G.S. 131E-96 the required risk management program requirement will be met:

- (1) Each hospital shall assign to a specific staff member responsibility for development and administration of the program.
- (2) Each hospital shall have a written policy statement evidencing a current commitment to the risk management program. In addition, the hospital shall develop written procedures and policies applicable to a risk management program which are reviewed annually and updated as necessary.
- (3) Each hospital shall maintain lines of communication between the risk management program and other functions relating to quality of patient care, safety, and professional staff performance.
- (4) Relevant educational programs for hospital employees, professional staff, and the governing body shall be presented at least annually.
- (5) A written report of the activities of the risk management program shall be provided at least annually to the governing body.

Statutory Authority G.S. 131E-96.

## SECTION .0400 - MEDICAL STAFF

### .0401 APPOINTMENT

(a) Medical staff appointments shall be made by the governing body upon recommendation of the medical staff.

(b) Appointments shall be made annually, at least while they are on a provisional status.

(c) Each appointment shall specify clearly and explicitly the nature of the clinical privileges granted, together with any specified conditions specified conditions of the appointment.

(d) An applicant shall be assigned to either the honorary medical staff; consulting medical staff; active medical staff; associate medical staff; courtesy medical staff; or to similar staff classifications.

Statutory Authority G.S. 131E-79.

### .0402 QUALIFICATIONS

(a) Every person admitted to practice in the hospital shall qualify for membership on the medical staff by submitting a signed application in writing which shall contain the following data:



age, year and school of graduation, date of licensure, statement of postgraduate or special training and experience, statement of the type of medicine the applicant desires to practice, a pledge that if appointed the applicant will comply with the rules and regulations of the hospital so far as they affect him and his membership on the medical staff, and include a statement of his own special qualifications and a resolution against Division of fees in accordance with the requirements of the American College of Surgeons.

(b) An individual file for each physician practicing in the hospital shall be maintained. Such file shall contain the information outlined above in (a) of this Rule as well as all actions taken by the medical staff and the governing board concerning the type of privileges granted and other applicable data.

*Statutory Authority G.S. 131E-79.*

#### .0403 ORGANIZATION

(a) In any hospital used by two or more physicians, the physicians and surgeons privileged to practice in the hospital shall be organized as a definite medical staff which shall initiate and, with the approval of the governing body of the hospital, adopt bylaws, and policies which specifically provide:

- (1) for eligibility for membership on the staff;
- (2) for the number and frequency of medical staff meetings and attendance requirements. Monthly meetings of the active staff are recommended. If monthly meetings are not held, then:
  - (A) monthly departmental conferences in those hospitals where the clinical services are well organized and each department is large enough to meet as a unit; or
  - (B) monthly meetings of the medical record and tissue committees to adequately appraise the quality of medical work are required.

In the case of the latter, appropriate action shall be taken not less than monthly by the executive committee of the staff and reports made to the active staff;

- (3) that on the basis of the patient's records the medical staff review and analyze at regular intervals their clinical experience in the various departments of the hospital.
- (b) All rules and regulations and policies

adopted by the medical staff and a roster of medical staff members shall be available to the Division upon request.

(c) The organized medical staff shall annually elect a staff member to be chief of staff, and departmentalization is appropriate, there shall be appointed or elected a qualified member of the medical staff to be responsible head or chief of each of the departments or services in the hospital such as obstetrics, pediatrics, surgery, medicine, etc.

(d) Such committees of the medical staff shall be appointed as are required for the necessary transaction of business.

*Statutory Authority G.S. 131E-79.*

#### .0404 SUPERVISION OF PATIENT CARE

All persons admitted to any institution covered by this Subchapter must be under the care of a physician who is in receipt of hospital privileges granted pursuant to G.S. 131E-85 and:

- (1) in good standing, and legally licensed to practice in North Carolina;
- (2) competent in his field.

*Statutory Authority G.S. 131E-79.*

#### .0405 ORDERS FOR MEDICATION AND TREATMENT

(a) No medication or treatment shall be administered except in response to the order of a physician, except as the medical staff may provide in its rules and regulations.

(b) Such orders shall be dated and recorded directly in the patient chart or in a computer or data processing system which provides a hard-copy printout of the order for the patient chart. A method must be established by each hospital governing body to identify all persons who record such orders and to safeguard against fraudulent recordings.

(c) All orders for medication or treatment shall be authenticated at the time of recordation by the ordering physician; provided, that verbal orders shall be authenticated within 24 hours after they are given by the ordering physician or by a physician involved with the care of the patient. Authentication must be accomplished by signature, initials, computer entry or code, or other method(s) not inconsistent with the laws, rules and regulations of any other applicable jurisdictions.

(d) The names of drugs must be recorded in full and not abbreviated.

(e) The medical staff shall have the authority to

~~approve medications used in the hospital and shall establish rules, not inconsistent with the provisions of this Rule, governing orders for habit forming or dangerous drugs.~~

*Statutory Authority G.S. 131E-79.*

#### **.0406 AVAILABILITY FOR EMERGENCIES**

~~One or more duly licensed physicians shall be available or on call for emergencies at all times.~~

*Statutory Authority G.S. 131E-79.*

#### **.0407 MEDICAL LIBRARY**

~~The hospital must maintain a medical reference library or basic textbooks sufficient to meet the needs and requirements of the services of the hospital.~~

*Statutory Authority G.S. 131E-79.*

### **SECTION .0500 - NURSING SERVICE**

#### **.0501 ORGANIZATION**

~~(a) The department of nursing and all nursing personnel shall be organized to provide complete and efficient care to each patient, and the authority and responsibility of each nurse and all nursing personnel shall be clearly defined by specific written policies.~~

~~(b) There shall be monthly meetings of the professional nursing staff to review and analyze the nursing service and to determine the quality and increase the efficiency of the nursing care rendered.~~

~~(c) Applications for employment shall be submitted in writing to the person responsible for nursing personnel, and each application shall contain accurate information as to the education, training, experience and personal background of each applicant. Prior to employment the hospital shall ascertain the accuracy of the employment application with respect to education, training, and experience of the applicant.~~

~~(d) All professional nursing personnel shall be registered in the State of North Carolina.~~

*Statutory Authority G.S. 131E-79.*

#### **.0502 PROFESSIONAL PERSONNEL**

~~(a) Nurse on Duty~~

~~(1) There shall be at least one registered nurse on duty at all times.~~

~~(2) Exception to this requirement may be considered for physician's~~

~~clinic hospital with limited beds when the physician is in the facility. However, in the absence of a physician a registered nurse must be on duty at all times.~~

~~(3) There shall either be at least one registered nurse on duty for each nursing unit; otherwise, there shall be adequate supervision by one or more circulating registered nurses.~~

~~(b) Competence. The superintendent or director of nursing service shall be a competent person with administrative and executive training and experience and a registered nurse, in the State of North Carolina.~~

~~(c) Amount of Care. Nursing care shall be that amount of professional and non professional care essential to provide proper treatment for the well being and the recovery of the patient.~~

~~(d) Supervision. All persons not employed by the hospital who render special duty nursing service in the hospital shall be under the supervision of the nursing supervisor of the department or service concerned. They shall be currently licensed in the State of North Carolina.~~

~~(e) Education. A program of in service education shall be maintained for all nursing service personnel.~~

*Statutory Authority G.S. 131E-79.*

#### **.0503 NON-PROFESSIONAL PERSONNEL**

~~(a) Practical nurses, subsidiary workers, orderlies and attendants assigned to the nursing service shall be given only those duties for which they are trained. They shall be under the supervision of a graduate nurse staff.~~

~~(b) All practical nurses shall be registered in the State of North Carolina.~~

*Statutory Authority G.S. 131E-79.*

#### **.0504 FACILITIES**

~~(a) Nurses' Station Facilities~~

~~(1) A locked, well illuminated medicine cabinet; nearby facilities for sink with hot and cold running water and a counter for the preparation of medications shall be provided.~~

~~(2) Where narcotics are kept at the nurses' station, a separate, locked, permanently secured cabinet or other facilities for narcotics shall be provided.~~

~~(3) There shall be adequate space for filing and recording patients' charts.~~



- (4) ~~Utility rooms shall be conveniently located, and shall provide adequate space and facilities for the proper cleansing, sterilizing (except where a central supply service is maintained), and storage of nursing supplies and equipment. Clean and dirty activities shall be segregated.~~
- (5) ~~Separate provisions shall be made for the emptying, cleaning and sterilizing of bedpans.~~
- (b) ~~Nursing Unit Facilities~~
  - (1) ~~Sterile supplies and equipment for the administration of blood transfusions, and intravenous and subcutaneous solutions shall be readily available.~~
  - (2) ~~Items such as intravenous stands, bedside rails, wheelchairs and stretchers shall be stored so as to permit free passage of personnel and equipment and to avoid blocking emergency exits.~~
- (c) ~~Cleaning of Materials and Equipment~~
  - (1) ~~All supplies and equipment used in patient care shall be properly cleaned or sterilized between use for different patients.~~
  - (2) ~~Methods for cleaning, handling and storing all supplies and equipment shall be such as to prevent the transmission of infection through their use.~~
  - (3) ~~After discharge of a patient from the hospital, the bed, mattress cover, bed linens, bedside furniture and equipment shall be properly cleaned and personal utensils shall be sterilized before reuse by other patients.~~

*Statutory Authority G.S. 131E-79.*

#### **.0505 PROCEDURES**

- (a) ~~Hot water bags shall be covered before use. Care must be exercised in their use to see that water does not exceed a safe temperature. When electric heating pads are used, they shall be maintained in safe working order.~~
- (b) ~~Restraints other than side rails for beds shall be used only on the written order of a physician and may be applied only when they are necessary to prevent injury to patients or to others.~~
- (c) ~~Physician orders for medication and treatment shall be issued, executed, recorded and authenticated in conformity with Rule .0405 of this Subchapter. Special procedures shall be detailed in writing and filed at the appropriate nursing station.~~

*Statutory Authority G.S. 131E-79.*

### **SECTION .0600 - PERSONNEL**

#### **.0601 PERSONNEL**

- (a) ~~All positions shall be authorized by the governing authority, either directly or through delegation by the governing authority to the administrator.~~
- (b) ~~Each prospective employee must submit an application of employment which provides a description of personal background, identification, training, experience and references.~~

*Statutory Authority G.S. 131E-79.*

#### **.0602 PERSONNEL POLICIES**

~~Explicit and uniform policies shall be established for each job classification, concerning pay days, sick leave, vacations, holidays, overtime, hospitalization, retirement plan, leaves of absence and other benefits or related conditions of employment. A statement of all such policies shall be furnished all personnel upon commencing work.~~

*Statutory Authority G.S. 131E-79.*

#### **.0603 HEALTH EXAMINATIONS**

- (a) ~~All personnel shall undergo pre-employment screening. Pre-employment screening procedures will be determined by the hospital's governing body and medical staff. Such procedures shall be recorded in writing.~~
- (b) ~~Follow up screening for all employees shall be determined by the hospital's governing body and medical staff. The procedures to be used shall be recorded in writing. Records of all screening activities shall be available for review by the Department.~~

*Statutory Authority G.S. 131E-79.*

#### **.0604 RECORDS**

~~An individual file shall be maintained for each employee. Such file shall contain the application for employment, physical examination results and other data which has a bearing on or is of value to the facility while the person is an active employee.~~

*Statutory Authority G.S. 131E-79.*

### **SECTION .0700 - LABORATORY SERVICES**

#### **.0701 FACILITIES**



~~The hospital shall provide laboratory services as required to perform the necessary laboratory tests and examinations for diagnosis and treatment of the classification of patients admitted. Equipment, when indicated, shall be calibrated in accordance with manufacturer's recommendations.~~

*Statutory Authority G.S. 131E-79.*

## **.0702 ORGANIZATION**

~~The laboratory shall be under the direct supervision of a clinical pathologist or a physician who has had special training in clinical laboratory diagnosis and whose judgment is accepted in doubtful findings.~~

*Statutory Authority G.S. 131E-79.*

## **.0703 RECORDS**

~~(a) All requests for laboratory service shall be in writing.~~

~~(b) A laboratory report on each procedure or autopsy, indicating the findings and individual who performed the test or examination, shall be filed in the patient's medical record.~~

*Statutory Authority G.S. 131E-79.*

## **.0704 AUTOPSY FACILITIES**

~~(a) An autopsy room shall be provided. If this room is not on the hospital premises, a written agreement shall be in effect under which such a room or rooms located in a mortuary establishment or establishments, or other appropriate facility, are made available to the hospital pathologist for the performance of postmortem examinations.~~

~~(b) Surfaces of walls, floors, fixtures and equipment shall be smooth and of washable material.~~

~~(c) The autopsy room shall have appropriate equipment, including at least one sink suitable for heavy cleaning and one sink for handwashing, each with hot and cold running water.~~

~~(d) The autopsy room shall have refrigeration facilities for at least one cadaver.~~

*Statutory Authority G.S. 131E-79.*

## **.0705 TISSUE REMOVAL**

~~(a) All specimens removed at surgery will be submitted for pathological examination, except specimens which by their nature do not permit meaningful examination, such as cataracts, foreign bodies (including synthetic materials, orthopedic appliances and bullets), residual portions of tissue~~

~~used as graft, normal tissue removed for exposure (such as a rib during thoracotomy or old scar tissue at laparotomy), newborn infant foreskin, normal placentas, teeth, toenails, fingernails, gallstones, traumatically amputated or surgically amputated gangrenous extremities or portions thereof, and debrided tissue from traumatic wounds. Both the medical staff and the governing board must formally approve a departure from the previously accepted practice of sending all tissue for examination. The rules and regulations of the medical staff must fully cover a policy on tissue examination.~~

~~(b) Any specimen eligible for exemption is also eligible for pathological examination at the discretion of the operating surgeon. Removed specimens that are not submitted for pathological examination will be described or documented in the operative record.~~

~~(c) The extent of the pathological examination shall be determined by the pathologist.~~

*Statutory Authority G.S. 131E-79.*

## **.0706 TESTS**

~~(a) Laboratory tests to be performed on a patient at the time of admission (if any) shall be established by the medical staff and be approved by the governing board of the hospital. In the event the medical staff and governing board elect not to establish routine laboratory tests for new admissions, the request for such tests shall be left to the discretion of the admitting physician.~~

~~(b) Serological tests for patients admitted shall be optional with the hospital. However, there shall be adequate records indicating that obstetrical patients have had a serological test during their current pregnancy.~~

~~(c) When laboratories outside of the hospital are used, such laboratories must be approved by the governing board and medical staff of the using hospital. In case of such usage, a legible copy of the laboratory report must be made a part of the pertinent patient record.~~

*Statutory Authority G.S. 131E-79.*

## **.0707 BLOOD BANK**

~~(a) Hospitals which provide for procurement, storage and transfusion of blood shall have acceptable facilities for such and shall meet the standards of the American Association of Blood Banks as outlined in the most current edition of Standards for a Blood Transfusion Service.~~

~~(b) The governing authority shall designate the~~

~~pathologist or other physician as physician in charge of the blood bank service.~~

~~(c) Records shall be kept on file indicating the receipt and disposition of all blood handled. Particular care shall be taken to ascertain that blood administered has not exceeded its expiration date, and meets all criteria for safe administration.~~

~~(d) The hospital shall make arrangements to secure on short notice all necessary supplies of whole blood, typed and cross matched as required, for emergencies.~~

*Statutory Authority G.S. 131E-79.*

#### **.0708 ELECTROCARDIOGRAPHY**

~~(a) Arrangements for necessary electrocardiographic procedures shall be provided. If such equipment is available on the premises there shall be provision for periodic calibration.~~

~~(b) If this equipment is provided at the hospital, a qualified physician shall be appointed to supervise the electrocardiographic technicians.~~

~~(c) The governing board shall appoint one or more physicians approved by the medical staff to interpret electrocardiograms made in the hospital.~~

~~(d) The interpreter's signed report shall be made a part of the patient's chart.~~

*Statutory Authority G.S. 131E-79.*

### **SECTION .0800 - RADIOLOGICAL SERVICES**

#### **.0801 FACILITIES**

~~(a) Hospitals shall have adequate space and equipment for diagnostic x ray and fluoroscopic examinations, including facilities for development and storage of radiographic film.~~

~~(b) The facilities must be so designed and the equipment installed as to provide the protection specified by National Bureau of Standards Handbook 76, Medical X Ray Protection Up To Three Million Volts.~~

*Statutory Authority G.S. 131E-79.*

#### **.0802 ORGANIZATION**

~~(a) The x ray department shall be under the supervision of a full time radiologist or consulting radiologist, or a physician experienced in radiology.~~

~~(b) Activities of the x ray service may extend to radio therapy, in which case the physician in charge shall be appropriately qualified.~~

~~(c) It is the responsibility of the hospital to~~

~~ensure that all x ray equipment is operated under professional supervision by competent personnel trained in the use of x ray equipment and knowledgeable of safety precautions recommended by the National Bureau of Standards.~~

*Statutory Authority G.S. 131E-79.*

#### **.0803 RECORDS**

~~(a) A written report on each x ray film taken shall be made a part of the patient's medical record.~~

~~(b) Radiology reports shall be signed by the physician responsible for the procedure.~~

~~(c) Records of personnel exposures to ionizing radiation must be maintained as stated in Rule .0804 of this Section.~~

~~(d) Copies of all reports made by private physicists surveying the radiographic facilities must be provided the Division.~~

*Statutory Authority G.S. 131E-79.*

#### **.0804 PERSONNEL MONITORING**

~~(a) Procedures for personnel monitoring shall be maintained for each individual working in the area of radiation where there is a reasonable probability of receiving one fourth of the maximum permissible dose.~~

~~(b) Personnel monitoring records resulting from the use of film badges or dosimeters must be maintained. Readings must be on at least a monthly basis.~~

~~(c) Upon termination of employment, each worker shall be provided with a summary of his exposure record.~~

~~(d) Permanent records of exposure on all monitored personnel must be maintained for review by the Division.~~

*Statutory Authority G.S. 131E-79.*

#### **.0805 RADIOACTIVE ISOTOPES**

~~(a) All radioactive isotopes, whether for diagnostic, therapeutic, or research purposes shall be received, handled, and disposed of in accordance with the requirements of the North Carolina Division of Radiation Protection Services.~~

~~(b) If radioactive isotopes are used, the hospital governing body shall appoint a radiation safety committee.~~

~~(c) This committee shall recommend policies and procedures in accord with recognized standards for the use of radioisotope materials, including special conditions as may be necessary~~



for personnel and equipment, and for reviewing any use of such materials for conformance with adopted policies recommended to the governing body.

Statutory Authority G.S. 131E-79.

## 0807 ADDITIONS OR RENOVATIONS TO THE RADIOGRAPHIC SUITE

Approval of initial and changed plans and specifications for structural and equipment installations must be obtained from the Division before work is commenced. Specifications must be furnished by a qualified physicist approvable to the Division. The Division will provide, upon request, a list of such individuals.

Statutory Authority G.S. 131E-79.

## SECTION .0900 - GENERAL CLINICAL SERVICES

### .0901 SURGERY FACILITIES

(a) Every hospital in which surgical operations are performed shall have an operating suite including an adequately designed operating room, proper scrubbing, sterilizing and dressing room facilities, safe storage for anesthetic agents and sufficient equipment and instruments in keeping with the requirements of modern surgery recognizing advances in surgical techniques and procedures.

(b) This suite shall be provided exclusively for surgical procedures and shall be located as not to be used as a passage between other parts of the hospital and shall not be subject to contamination from other parts of the hospital.

Statutory Authority G.S. 131E-79.

### .0902 SURGERY ORGANIZATION

(a) The surgical staff shall consist of physicians with delineated surgical privileges as specified in the corporate or medical bylaws.

(b) The governing body shall assure that surgical privileges are granted only to licensed physicians who have relevant clinical training and experience.

(c) A roster of surgeons with the delineation of their privileges shall be maintained by the operating room supervisor.

(d) The surgical services shall make provisions for surgeons with privileges to be available at all times for emergency surgery, and for post operative clinical management.

(e) The operating room shall be under the

supervision of a registered nurse with relevant training and experience.

(f) Sufficient professional and non professional personnel shall be available to provide the necessary supporting services and to maintain an aseptic environment.

Statutory Authority G.S. 131E-79.

### .0903 SURGERY PROCEDURES

(a) Before a patient requiring general or regional anesthesia undergoes surgery, the following safeguards must be fulfilled and recorded in the chart:

(1) A medical history, if obtainable, shall be taken to ascertain the condition for which surgery is recommended and to evaluate the patient's ability to withstand surgery. This shall be supplemented by an additional history taken by either the surgeon or anesthetist concerning drug sensitivities, recent food intake and other pertinent facts.

(2) A physical examination shall be performed in sufficient detail to identify significant abnormalities and to evaluate the patient's cardiac and respiratory ability to withstand surgery.

(3) Each patient should have those laboratory procedures determined necessary by the rules and regulations of the medical staff or prescribed in appropriate standing orders.

(4) Consultations as required by the medical staff rules and regulations shall be obtained.

(5) A provisional diagnosis shall be established.

(6) Consent of the patient or legal guardian for surgery shall be obtained in accordance with the policy of the institution.

(b) Before a patient undergoes surgery, the following additional safeguards shall also be fulfilled:

(1) verification of the patient's identity in accordance with the policies of the institution;

(2) verification of a surgeon's authority to undertake the proposed operation.

(c) Any of the above pre-operative procedures may be waived, if in the judgment of the attending surgeon, the risk of delay endangers the patient's life.



(d) ~~An acceptable aseptic technique shall be observed by members of the surgical team in all operative procedures. Proper care shall be taken to prevent contamination of the surgical field, sterile tables or operating team by any cause.~~

(e) ~~After an operation on a septic case, the operating room shall be thoroughly cleansed in a manner adequate for the type of contamination existing.~~

(f) ~~An accurate and complete description of the technique of operation and the findings and a statement of organs or tissues removed together with the post operative diagnosis shall be entered by the surgeon in the patient's record as soon as practicable following the operation.~~

(g) ~~All hospitals providing surgical services shall have available facilities for the pathological examination of tissue specimens. This may be provided either on the premises or by arrangement through affiliation, or other means, with a pathological laboratory.~~

(h) ~~A chronological register of surgical operations shall be maintained in the surgical suite.~~

*Statutory Authority G.S. 131E-79.*

#### .0904 PROTECTION AGAINST ANESTHETIC EXPLOSIONS

Rule 10 NCAC 3C .1204 shall control.

*Statutory Authority G.S. 131E-79.*

#### .0905 OBSTETRICS FACILITIES

##### (a) Maternity

(1) ~~Obstetrical facilities shall be located and arranged so as to provide for every reasonable protection of mothers from infection and from cross infection.~~

(2) ~~Standards of the American College of Obstetricians and Gynecologists as outlined in the most current edition of Manual of Standards in Obstetric Gynecologic Practice shall be used as a guide.~~

##### (b) Services and Care

(1) ~~There must be satisfactory capability for the care of patients in labor. This shall include identification of high risk mothers and fetuses, continuous electronic fetal monitoring, caesarean delivery capability within 30 minutes, blood and fresh frozen plasma for transfusion, anesthesia on a 24 hour basis, radiology and ultra sound examination, neonatal resuscitation,~~

~~consultation and transfer agreement.~~

(2) ~~Rooms used for patients in labor shall afford privacy, and be conveniently located with reference to the delivery room. If labor rooms also serve as "birthing rooms", they shall be equipped to handle obstetric and neonatal emergencies.~~

(3) ~~If analgesia is used, beds shall be equipped with side rails.~~

(4) ~~There must be facilities for examination and preparation of patients as required by the attending physician.~~

##### (c) Delivery Room

(1) ~~Rooms in which patients are usually delivered shall be used for no other purpose than for the completion of labor and delivery. Each room shall be provided with the necessary facilities and equipment as determined by the medical staff, principally the obstetrical service. If circumcisions are performed in the delivery rooms, they shall be confined to hospital newborns.~~

(2) ~~A written schedule of procedures for cleaning and setting up the delivery room following each delivery shall be placed in or near the room.~~

(3) ~~The delivery room shall be staffed and equipped to handle obstetric emergencies and to provide neonatal resuscitation.~~

(4) ~~Incubator [see Rule .0908(a)(5) of this Subchapter].~~

(5) ~~Facilities for compliance with G.S. 130A 173, regarding treatment of the eyes of newborn shall be maintained.~~

(6) ~~An acceptable means of identifying each infant shall be available in every delivery room.~~

(7) ~~Protection against anesthetic explosion (see Rule .1204 of this Subchapter).~~

*Statutory Authority G.S. 131E-79.*

#### .0906 OBSTETRICS ORGANIZATION

(a) ~~An on call schedule or other procedure shall be established to ensure that a physician with obstetrical privileges is available within 30 minutes at all times to perform deliveries at the hospital.~~

(b) ~~Every birth occurring in a hospital shall be attended by a medical doctor who shall possess the qualifications prescribed in Rule .0402 of this Subchapter. Nothing in this Paragraph is intended to prevent members of the hospital resident staff~~

when acting under the authority and supervision of the attending doctor, from attending at births.

(c) ~~The physician shall be notified when the patient is admitted and immediately upon onset of labor.~~

(d) ~~A registered nurse, with relevant training and experience in obstetric and newborn care, shall be responsible at all times for the nursing care of maternity patients and newborn infants.~~

(e) ~~A qualified member of the health care team shall be assigned responsibility for observing the patient, monitoring her progress in labor and recording all pertinent information.~~

Statutory Authority G.S. 131E-79.

## 0907 OBSTETRICS PROCEDURES

(a) ~~Routine nursing procedures for care of obstetric patients shall be prepared in written form.~~

(b) ~~Accurate and complete medical records must be provided for all maternity patients, and a separate record maintained for infants.~~

(c) ~~Any indication of infection must be reported immediately to the attending physician in charge of the patient and to the hospital administration.~~

(d) ~~Immediate segregation and isolation of all mothers with infection, fever or other condition inimical to the safety and welfare of others must be provided in a separate room.~~

(e) ~~A mother shall be considered infected if:~~

(1) ~~She has a communicable disease or is suspected of such, or if she is a carrier;~~

(2) ~~She nurses an infected infant;~~

(3) ~~She is delivered outside the maternity unit of the hospital in which she is afterwards cared for;~~

(4) ~~She has an unexplained fever during the puerperium.~~

(f) ~~For the protection of mothers, every institution receiving maternity patients shall observe the following rules and regulations:~~

(1) ~~The number of visitors to a maternity patient shall not exceed two, exclusive of the husband, at any time;~~

(2) ~~Visitors (including children) known to have an existing or recent communicable infection, as well as those having contact with such infection, shall be excluded;~~

(3) ~~Visitors must not sit on beds.~~

Statutory Authority G.S. 131E-79.

## 0908 NEWBORN FACILITIES

(a) ~~Nursery~~

(1) ~~A nursery, not to be used for any other purpose, must be provided for the newborn with adequate space, light and ventilation.~~

(2) ~~The nursery shall be located and arranged as to provide for complete protection of newborn infants from infection and from cross infection from patients in other services in the hospital.~~

(3) ~~There shall be provisions for a suspect nursery for infants suspected of a contagious, infectious, or communicable disease; and there shall be provisions for the complete isolation of infants with a known infectious, contagious or communicable disease. Newborn and older infants admitted from the outside shall not be cared for in the newborn nursery.~~

(4) ~~The newborn nursery shall be staffed and equipped to provide neonatal resuscitation.~~

(5) ~~Facilities without an intensive care nursery shall establish procedures and methods to transport sick neonates to a regional neonatal unit.~~

(6) ~~The premature should be cared for in a separate nursery or should be segregated in the newborn nursery.~~

(7) ~~A large plainly legible wall thermometer shall be provided for the nursery.~~

(8) ~~An accurate scale for weighing newborn shall be provided.~~

(9) ~~Running hot and cold water and suitable receptacles for the disposal of waste and soiled linens shall be provided in or adjacent to each nursery.~~

(b) ~~Formula Room~~

(1) ~~There shall be adequate facilities for the storage, handling and preparation of formulas for infants apart from food provided to adult patients.~~

(2) ~~A room must be designated for the exclusive preparation of formula unless the hospital relies entirely on a prepackaged sterile disposable formula system.~~

(3) ~~Dirty bottles and accessories should be stored away from the counter area where formulas are prepared, sterilized and cooled.~~

(4) ~~When formula is prepared on site, sterilization and refrigeration equipment~~



must be provided in the formula room. When a disposable formula system is used, adequate storage space shall be provided and an aseptic environment maintained in handling prepackaged formula.

Statutory Authority G.S. 131E-79.

#### .0909 NEWBORN ORGANIZATION

(a) A registered nurse shall be responsible at all times for the nursing care of newborn infants.

(b) Nursery personnel shall observe universal infection control precautions.

Statutory Authority G.S. 131E-79.

#### .0910 NEWBORN PROCEDURES

(a) A system of positive and secure cross identification of mother and newborn infant shall be adopted by the hospital.

(b) The medical staff shall provide for a physical examination of each newborn infant as soon as practicable after birth, and periodic re-examination prior to discharge from the hospital, with findings in each instance recorded.

(c) The nursery shall be supplied with a continuous supply of oxygen. Routine administration of oxygen to newborn infants is prohibited and concentration of oxygen shall be restricted to levels below 40 percent, except where the physician incorporates in his written order the reason for prescribing a greater concentration, and specifies the concentration desired.

(d) Visitors may not enter the nursery.

(e) A view window where babies are shown to visitors must be one fourth inch wired plate glass with no section larger than 1,296 square inches.

(f) No visitors except the father shall be allowed in the mother's room during nursing hours.

(g) In cases where the newborn infant remains in the mother's room (rooming in), there shall be handwashing facilities and nursing supervision of mother and infant.

(h) Standards or recommendations of the American Academy of Pediatrics for hospital care of newborn infants shall be used as a guide.

Statutory Authority G.S. 131E-79.

#### .0911 PEDIATRICS

(a) Facilities

(1) A hospital providing pediatric care shall have proper facilities for the caring of children apart from the services for

adult patients and apart from the newborn nursing service.

(2) There shall be proper facilities and procedures for the isolation of children with infectious, contagious and communicable conditions.

(b) Organization. Nursing personnel shall be assigned and located, relative to the pediatric area or accommodations, as to maintain supervision of children at all times.

(c) Procedures. Standards or recommendations of the American Academy of Pediatrics for hospital care of newborn infants shall be used as a guide.

Statutory Authority G.S. 131E-79.

#### .0912 DENTISTRY

(a) A Hospital offering dental services shall comply with the requirements of this Section.

(b) Facilities. The space and equipment allocated to the dental services shall be in accordance with generally accepted standards of practice.

(c) Organization

(1) All dentists on the dental service of the institution shall be:

(A) Graduates of schools approved or tentatively approved by the Council on Dental Education;

(B) Licensed to practice dentistry in the State of North Carolina and be eligible for membership in the American Dental Association or National Dental Association and local and state dental societies;

(C) When special work in oral surgery, periodontics, orthodontics and other specialties of dentistry is to be undertaken, the dentist shall be granted privileges in these areas.

(2) Institutions providing dental services may provide for dental interns and residents appointed according to the usual regulations for the hospital. Dental internships and residencies shall conform to requirements for approval of dental internships and residencies.

(3) Dental services shall be under the direction of a dentist, preferably one engaged in the general practice of dentistry, and shall function as other services do.

(4) Written policies and procedures shall be provided for dental services.



- (5) ~~Basic and current reference material shall be available.~~
- (6) ~~All requests for diagnostic or treatment services shall be signed by either the attending dentist or physician.~~
- (7) ~~Records shall be a part of the hospital medical records system. A uniform method shall be established for recording data.~~

(d) ~~Procedures. Patients admitted by a dentist to the hospital for dental care shall be given the same medical appraisal, by a physician or surgeon having a license to practice in North Carolina, as those admitted to other services.~~

*Statutory Authority G.S. 131E-79.*

#### 0913 PSYCHIATRIC OR SUBSTANCE ABUSE SVCS: APPLICABILITY OF RULES

~~The rules contained in 10 NCAC 3C .0913-.0917 shall apply only to inpatient services unless otherwise specified.~~

*Statutory Authority G.S. 131E-79.*

#### 0914 DEFINITIONS APPLICABLE TO PSYCHIATRIC OR SUBSTANCE ABUSE SVCS

(a) ~~"Certified counselor" means an alcoholism, drug abuse or substance abuse counselor who is certified by the North Carolina Substance Abuse Professional Certification Board.~~

(b) ~~"Certified substance abuse counselor/supervisor" means an individual who is "certified counselor" as defined in 10 NCAC 3C .0914(a) and is designated by the North Carolina Substance Abuse Professional Certification Board as a qualified substance abuse supervisor.~~

(c) ~~"Clinical/professional supervision" means regularly scheduled assistance by a qualified mental health professional or a qualified substance abuse professional to a staff member who is providing direct, therapeutic intervention to a client or clients. The purpose of clinical supervision is to ensure that each client receives appropriate treatment or habilitation which is consistent with accepted standards of practice and the needs of the client.~~

(d) ~~"Detoxification service" means a service provided in a unit or department whose primary purpose is to treat substance abuse through detoxification.~~

(e) ~~"Direct care staff" means an individual who provides active direct care, treatment, or~~

~~rehabilitation or habilitation services to clients on a continuous and regularly scheduled basis.~~

(f) ~~"Psychiatric nurse" means an individual who is licensed to practice as a registered nurse in the State of North Carolina by the North Carolina Board of Nursing and who is a graduate of an accredited master's level program in psychiatric mental health nursing with two years of experience or has a master's degree in behavioral science with two years of supervised clinical experience in psychiatric mental health nursing or has four years of supervised clinical experience in psychiatric mental health nursing.~~

(g) ~~"Psychiatric service" means a service provided in a unit or department whose primary purpose is to treat mental illness.~~

(h) ~~"Psychiatric social worker" means an individual who holds a master's degree in social work from an accredited school of social work and has two years of clinical social work experience.~~

(i) ~~"Psychiatrist" means an individual who is licensed to practice medicine in North Carolina and who has completed an accredited training program in psychiatry.~~

(j) ~~"Psychologist" means an individual licensed to practice psychology in North Carolina by the North Carolina State Board of Examiners of Practicing Psychologists.~~

(k) ~~"Qualified mental health professional" means any one of the following: psychiatrist, psychiatric nurse, practicing psychologist, psychiatric social worker, an individual with at least a master's degree in a related human service field and two years of supervised clinical experience in mental health services or an individual with a baccalaureate degree in a related human service field and four years of supervised clinical experience in mental health services.~~

(l) ~~"Qualified substance abuse professional" means an individual who is:~~

- (1) ~~certified by the North Carolina Substance Abuse Professional Certification Board; or~~
- (2) ~~certified by the National Consortium of Chemical Dependency Nurses, Inc.; or~~
- (3) ~~a graduate of a college or university with a baccalaureate or advanced degree in a human service related field with documentation of at least two years of supervised experience in the profession of alcoholism and drug abuse counseling.~~

(m) ~~"Restraint" means the limitation of one's freedom of movement and includes the following:~~

- (1) ~~mechanical restraint which means~~

restraint of a client with the intent of controlling behavior with mechanical devices which include, but are not limited to, cuffs, ankle straps, sheets or restraining shirts.

- (2) ~~physical restraint which means restraint of a client until calm. As used in these Rules, the term physical restraint does not apply to the use of professionally recognized methods for therapeutic holds of brief duration (five minutes or less).~~

(n) ~~"Restrictive facility" means a facility so designated by the Division of Facility Services which uses mechanical restraint or seclusion in accordance with G.S. 122C-60 in order to restrain a client's freedom of movement.~~

(o) ~~"Seclusion" means isolating a client in a separate locked room for the purpose of controlling a client's behavior.~~

(p) ~~"Substance abuse service" means service provided in a unit or department whose primary purpose is to treat substance abuse.~~

Statutory Authority G.S. 131E-79.

#### .0915 STAFFING FOR PSYCHIATRIC OR SUBSTANCE ABUSE SERVICES

##### (a) General.

- (1) ~~A physician shall be present in the facility or on-call 24 hours per day. The medical appraisal and medical treatment of each patient shall be the responsibility of a physician.~~
- (2) ~~Each facility shall determine its overall staffing requirements based upon the age categories (child, adolescent, adult, elderly), clinical characteristics, treatment requirements and numbers of patients.~~
- (3) ~~There shall be a sufficient number of appropriately qualified clinical and support staff to assess and address the clinical needs of the patients.~~
- (4) ~~Staff members shall have training or experience in the provision of care in each of the age categories assigned for treatment.~~

##### (b) Psychiatric Services.

- (1) ~~Staff coverage for psychiatric services shall include at least one each of the following: psychiatrist, psychiatric nurse, psychologist, and a psychiatric social worker.~~
- (2) ~~A qualified mental health professional~~

~~shall be readily available by telephone or page and able to reach the facility within 30 minutes on a 24 hour basis.~~

- (3) ~~Each clinical or direct care staff member who is not a qualified mental health professional shall receive professional supervision from a qualified mental health professional.~~

- (4) ~~When detoxification services are provided, there shall be liaison and consultation with a qualified substance abuse professional prior to the discharge of a client.~~

##### (e) Substance Abuse Services.

- (1) ~~At least one registered nurse shall be on duty during each shift.~~

- (2) ~~Certified counselors or qualified substance abuse professionals shall be employed at the ratio of one staff member for each ten inpatients or fraction thereof. In documented instances of bona fide shortages of certified persons, uncertified individuals expecting to become certified may be employed for a maximum of 38 months without qualifications.~~

- (3) ~~The hospital shall have a minimum of two staff members providing care, treatment and services directly to patients on duty at all times and maintain a shift ratio of one staff member for each 20 or less inpatient with the following exceptions:~~

- (A) ~~When there are minor inpatients there shall be staff available on the ratio of one staff member for each 5 minor inpatients or fraction thereof during each shift from 7:00 a.m. to 11:00 p.m.~~

- (B) ~~When detox services are offered there shall be no less than one staff member for each nine inpatients or fraction thereof on each shift.~~

- (4) ~~A certified substance abuse counselor/supervisor shall be employed in accordance with requirements of the North Carolina Substance Abuse Professional Certification Board when the Board's certification requirements go into effect, but a certified substance abuse counselor/supervisor shall be required no earlier than January 1, 1993.~~

Statutory Authority G.S. 131E-79.



**0916 PSYCHIATRIC OR SUBSTANCE ABUSE SERVICES RECORD REQUIREMENTS**

(a) In addition to the general record keeping requirements of Rule 10 NCAC 3C .1404, specialized assessment and treatment plans for individuals undergoing psychiatric or substance abuse treatment are as follows:

- (1) Within 24 hours following admission each individual shall have a completed admission assessment. The initial assessment shall include the reason for admission, admitting diagnosis, mental status including suicide potential, diagnostic tests or evaluations, and a determination of the need for additional information to include the potential for the physical abuse of self or others and a family assessment when a minor is involved.
- (2) Within 72 hours following admissions a preliminary individual treatment plan shall be completed and implemented.
- (3) Within ten days following inpatient admission a comprehensive individual treatment plan shall be developed and implemented. For outpatient programs the plan shall be developed and implemented within 30 days of admission to treatment.

(b) Individual treatment plans for psychiatric and substance abuse patients shall be developed in partnership with the patient or individual acting in behalf of the patient. Clinical responsibility for the development and implementation of the plan shall be clearly designated. Minimum components of the comprehensive treatment plan shall include diagnosis and time specific short and long term measurable goals, strategies for reaching goals, and staff responsibility for plan implementation. The plan shall be revised as medically or clinically indicated.

(c) Progress notes shall be entered in each individual's record. Included is information which may have a significant impact on the individual's condition or expected outcome such as family conferences or major events related to the patient. Patient status shall be documented each shift for any inpatient psychiatric or substance abuse services, and on a per visit basis for outpatient psychiatric and substance abuse services.

(d) For each individual to whom substance abuse services are provided, a written plan for aftercare services shall be developed which minimally includes:

- (1) plan for delivering aftercare services;

including the aftercare services which are provided; and

- (2) provision for agreements with individuals or organizations if aftercare services are not provided directly by the facility.

*Statutory Authority G.S. 131E-79.*

**.0917 COMPLIANCE WITH STATUTORY REQUIREMENTS**

(a) Facilities providing psychiatric or substance abuse services shall develop procedures to ensure the rights of psychiatric and substance abuse patients in accordance with North Carolina statutes addressing the rights of psychiatric and substance abuse patients. Statutes addressing such rights are as follows:

- (1) G.S. 122C 51. Declaration of policy on clients' rights;
- (2) G.S. 122C 52. Right to confidentiality;
- (3) G.S. 122C 53. Exceptions; client;
- (4) G.S. 122C 54. Exceptions; abuse reports and court proceedings;
- (5) G.S. 122C 55. Exceptions; care and treatment;
- (6) G.S. 122C 56. Exceptions; research and planning;
- (7) G.S. 122C 57. Right to treatment and consent to treatment;
- (8) G.S. 122C 58. Civil rights and civil remedies;
- (9) G.S. 122C 59. Use of corporal punishment;
- (10) G.S. 122C 60. Use of physical restraints or seclusion;
- (11) G.S. 122C 61. Treatment rights in 24 hour facilities;
- (12) G.S. 122C 62. Additional rights in 24 hour facilities;
- (13) G.S. 122C 65. Offenses relating to clients; and
- (14) G.S. 122C 66. Protection from abuse and exploitation: reporting.

(b) Facilities providing psychiatric or substance abuse services shall develop procedures to protect confidentiality of information regarding communicable disease and conditions in compliance with G.S. 130A 143.

*Statutory Authority G.S. 131E-79.*

**SECTION 1000 - EMERGENCY AND OUTPATIENT DEPARTMENTS**



### .1001 EMERGENCY FACILITIES

(a) ~~Hospitals shall have an emergency service with facilities to meet the hospital services to be provided. At least one room shall be continuously available for the reception, examination and initial treatment of emergency patients. This room shall be independent of the operating room suite.~~

(b) ~~Adequate supplies and equipment shall be available and in readiness for use. Facilities shall be available for the administration of blood, blood plasma and intravenous medication as well as facilities for the control of bleeding, emergency splinting of fractures, and the administration of oxygen, anesthesia and suction.~~

(c) ~~Appropriate drugs and solutions, as specified by the medical staff, shall be immediately available.~~

*Statutory Authority G.S. 131E-79.*

### .1002 EMERGENCY ORGANIZATION

(a) ~~The medical staff shall provide for prompt, competent medical attention for all emergency patients as their respective needs may dictate. This plan shall include provisions for specialist consultation as well as initial reception and evaluation of patients.~~

(b) ~~Schedules, names and telephone numbers of all physicians and others on emergency call duty, including alternates, shall be maintained.~~

(c) ~~The medical staff shall assure itself of the competence of all physicians having emergency room duties, and shall provide for necessary refresher training.~~

(d) ~~One or more licensed nurses shall be assigned to emergency room duty at all times. This assignment need not be exclusive of other duties, but must have priority over all other duties whenever a patient is brought to the emergency department. Alternates shall be provided in order that the coverage will be continuous. Regular and alternate personnel, if assigned other duties, shall be stationed within easy reach of the emergency room.~~

(e) ~~All emergency room personnel shall receive orientation and training in the reception and care of emergency patients.~~

(f) ~~Complete lists of standard equipment, supplies, and procedures applying to the emergency room shall be in writing and copies thereof shall be posted in the emergency room or suite.~~

(g) ~~An emergency room procedure manual shall be prepared for reference in the emergency room.~~

*Statutory Authority G.S. 131E-79.*

### .1003 EMERGENCY PROCEDURES

(a) ~~A record shall be made of each patient examined or treated in the emergency room including date, name, address, age, place of injury, diagnosis, treatment and disposition. The records shall be filed in the medical record department as permanent records.~~

(b) ~~If anesthesia, other than local, administered in the emergency room, the provisions of Section .1200 of this Subchapter shall be observed.~~

*Statutory Authority G.S. 131E-79.*

### .1004 POISON CONTROL

(a) ~~The location and telephone number of the nearest poison control center shall be posted for immediate reference.~~

(b) ~~A list of poison antidotes shall be maintained in the hospital and shall be posted in the emergency room.~~

*Statutory Authority G.S. 131E-79.*

### .1005 DISASTER AND MASS CASUALTY PROGRAM

(a) ~~Each hospital, through joint effort of the governing board, administrator, medical staff, and hospital personnel, shall develop a written disaster and mass casualty plan for the reception, treatment and disposition of casualties from a single catastrophe. The program may be worked out in cooperation with other hospitals of the area and with other concerned agencies.~~

(b) ~~This program shall include the possibility of disaster involving loss of the hospital or serious impairment of its facilities.~~

*Statutory Authority G.S. 131E-79.*

### .1006 OUTPATIENT DEPARTMENT

(a) ~~Facilities. Where outpatient services are maintained, the type and quantity of facilities shall be such as to provide safe, prompt service to the number and types of patients served.~~

(b) ~~Organization~~

(1) ~~Only members of the medical staff of the hospital shall be permitted to practice in the outpatient service, and the privileges of physicians and dentists in the outpatient service shall be defined in terms of their training and ability, in the same manner as their~~

privileges in the inpatient services. The governing board may create special categories of staff membership, limited to practice in the outpatient service.

- (2) Nursing personnel shall be present in sufficient number to render adequate service to patients and physicians.

(c) Procedures. Adequate and complete records shall be kept on all outpatients. These records should contain sufficient identification data, history, and reports of all examinations and treatments. The records shall be readily available for reference upon subsequent inpatient or outpatient visits.

Statutory Authority G.S. 131E-79.

## SECTION .1100 - PHYSICAL MEDICINE

### 1101 PHYSICAL THERAPY

Hospitals which provide physical therapy service shall, regardless of the scope of such service, establish and enforce policies of operation including the following:

- (1) The service shall be supervised by a licensed physician or committee of the medical staff.
- (2) Procedures and treatments shall be given only on the written order of a member of the medical staff.
- (3) Records shall be maintained of all orders, procedures, and treatments, and for inpatients, shall be made a part of the medical record.
- (4) Safety policies shall be established regarding use of equipment and handling of patients.

Statutory Authority G.S. 131E-79.

### 1102 OCCUPATIONAL THERAPY

Hospitals which provide occupational therapy service shall, regardless of the scope of such service, establish and enforce policies of operation including the following:

- (1) The service shall be supervised by a licensed physician or committee of the medical staff, and shall be administered by properly qualified occupational therapists.
- (2) Procedures and treatments shall be given only on the written order of a member of the medical staff.
- (3) Records shall be maintained of all orders,

procedures and treatments, and for inpatients, shall be made a part of the medical record.

- (4) Safety policies shall be established regarding use of equipment and handling of patients.

Statutory Authority G.S. 131E-79.

## SECTION .1200 - ANESTHESIA

### .1201 FACILITIES

(a) In the surgical department or Division of any hospital, there shall be facilities and equipment for the administration of anesthesia, commensurate with the needs of the hospital.

(b) Construction, storage, and equipment shall be in accordance with the standards of the National Fire Protection Association (N.F.P.A.), incorporated in Bulletin No. 56, "Code for the Use of Flammable Anesthetics," dated May, 1962 or subsequently.

Statutory Authority G.S. 131E-79.

### .1202 ORGANIZATION

(a) The administration of general or regional anesthesia or analgesia shall be performed only by physicians or nurses approved by the medical staff on the basis of an evaluation of their training, experience and ability and in the case of physicians specifically appointed to such practice by the governing board.

(b) Such approved personnel shall be available at all times in sufficient numbers to meet the needs of the hospital.

(c) The anesthesia department shall be under the supervision of a full time anesthesiologist or consulting anesthesiologist. If only nurse anesthetists are employed, medical supervision shall be provided by the chief of surgical service or by an alternate member of that service.

Statutory Authority G.S. 131E-79.

### .1203 PROCEDURES

(a) Pre-operative Procedures. Operations under a general anesthetic (inhalation, spinal, intravenous or rectal) shall not be performed nor a general anesthetic given until the pre-operative procedures outlined in Rule .0903 of this Subchapter, have been complied with.

(b) Exception. Any of the pre-operative procedures may be waived, if in the judgment of the attending physician or surgeon, the risk of



delay endangers the patient's life.

(e) Recovery

- (1) Patients under or recovering from anesthesia shall remain under continuous, direct nursing supervision until vital signs have become stabilized.
- (2) Any nurse performing this duty shall have been instructed in the management of post anesthetic patients, shall have no other duties during the time she is supervising such patients, and shall have immediate recourse to the attending surgeon or anesthesiologist, or qualified substitute, present in the hospital.

Statutory Authority G.S. 131E-79.

# **.1204 PROTECTION AGAINST ANESTHETIC ACCIDENTS**

(a) The hospital shall recognize the dangers of accidental ignition of anesthetic gases to patients and others and shall make provisions to minimize this hazard in accordance with the National Fire Protection Association standards cited above.

(b) Persons administering anesthesia shall check to ascertain that anesthetic gas cylinders are properly installed on the anesthesia machines and that all cylinders and machine valves are properly labeled or color coded.

(c) All anesthesia machines shall incorporate pin indexing in the interest of avoiding improper installations of gas cylinders.

Statutory Authority G.S. 131E-79.

## **SECTION .1300 - PHARMACY**

### **.1301 FACILITIES**

(a) Hospitals operating and maintaining a pharmacy as defined by G.S. 90-85.3 shall have adequate space and facilities for storage, compounding and dispensing of drugs. All areas shall be well illuminated.

(b) All pharmacies, without regard to the extent and frequency of supervision by a registered pharmacist, shall be registered with the North Carolina Board of Pharmacy. (Information concerning registration procedures may be obtained from the North Carolina Board of Pharmacy, P.O. Box H, Carrboro, North Carolina 27510.)

(c) There shall be refrigeration for biologicals and such drug products which require refrigeration.

Statutory Authority G.S. 131E-79.

### **.1302 ORGANIZATION**

(a) A hospital pharmacy shall be under the supervision of a full or part time qualified licensed pharmacist registered in the State of North Carolina. Drugs, medications and poisons located in areas of the hospital other than the pharmacy shall likewise be under the general supervision of the registered pharmacist.

(b) A pharmacy committee to give advice on pharmaceutical problems shall be established. Such committees shall meet at regular intervals and the members shall be chosen from the several Divisions of the medical staff as well as include the hospital pharmacist and administration.

Statutory Authority G.S. 131E-79.

### **.1303 PROCEDURES**

(a) The hospital shall use drugs, chemicals, and pharmaceutical preparations which meet quality standards of the United States Pharmacopeia, National Formulary, New and Non Official Drug Book or other recognized compendia.

(b) All medicines, poisons, and stimulants kept on nursing units shall be plainly labeled and stored in a specially designed, well illuminated medicine cabinet, closet, or storeroom, and made accessible only to authorized personnel.

(c) Suitable control and records shall be maintained for the safe keeping and proper utilization of those central nervous system stimulants used for mood modification and barbiturates used for hypnotic and somnifacient purposes as required by North Carolina and federal laws or as dictated by considerations of safe pharmacy practice.

(d) There shall be an automatic stop order on dangerous drugs. Drugs which fall into this classification are narcotics, antibiotics, sedative and hypnotics, and anti-coagulants. Hospital policy in this matter shall be developed by the medical staff and parallel the recommendations of the Joint Commission on Accreditation of Healthcare Organizations.

(e) When orders have been discontinued or the patient discharged, all of his medications shall be discarded, returned to the pharmacy, or discharged with the patient according to the doctor's orders.

(f) If narcotics that are administered from the hospital stock are procured under a federal permit, each dose shall be recorded on a permanent narcotic record, which, in accordance with federal regulations, must provide the date, hour, name



patient, kind of narcotic, dose, and by whom administered. If a narcotic is administered from an outside prepared prescription, it shall be sufficient to record each dose on the clinical record of the patient.

(g) Narcotics must be securely locked at all times and accessible only to authorized persons.

(h) Suitable and proper records shall be kept of the transactions of the pharmacy as required by North Carolina and federal laws or as dictated by considerations of safe pharmacy practice.

Statutory Authority G.S. 131E-79.

## SECTION .1400 - MEDICAL RECORDS

### 1401 FACILITIES

(a) The medical records department shall be conveniently located.

(b) Provisions shall be made for safe storage of all medical records.

(c) If medical records are stored in a separate building, it shall be of fire resistive construction.

Statutory Authority G.S. 131E-79.

### 1402 ORGANIZATION

The responsibility for supervising, filing and indexing of medical records shall be delegated to a trained medical records librarian or to a responsible employee of the hospital.

Statutory Authority G.S. 131E-79.

### 1403 PROCEDURES

(a) A system of filing and indexing according to one of the acceptable nomenclatures shall be adopted.

(b) Medical records shall be indexed for: the patient, the disease, the medical or surgical procedure involved, the physician, the results and any other pertinent information deemed necessary by the medical staff.

(c) A member or committee of members shall be appointed by the medical staff to ascertain whether the medical records are adequate and up to date, and to formulate rules and regulations and assist in their enforcement.

(d) Records of patients are the property of the hospital and must not be taken from the hospital except under a subpoena. When taken from the hospital property under subpoena, they must be returned to the hospital at the end of the hearing for which they were directed to be procured. An

administrative officer shall be responsible for the enforcement of this Rule.

(e) It is the responsibility of the hospital to safeguard the information on the record against loss, tampering, or use by unauthorized persons.

(f) Only a physician, member of the house staff, physician assistant or nurse practitioner is allowed to write or dictate medical histories and physical examinations. The use of a physician assistant or nurse practitioner in performing these activities must be approved by the hospital's governing body and medical staff. If medical histories and/or physical examinations are performed by a physician assistant or nurse practitioner, he or she must be approved to perform such services under the license of the physician or group of physicians responsible for his or her medical acts as approved by the Board of Medical Examiners of the State of North Carolina under General Statute 90-18. Histories and physicals performed by a physician assistant or nurse practitioner must be countersigned by the responsible physician(s).

Statutory Authority G.S. 131E-79.

### .1404 CONTENT

(a) Adequate and complete medical records shall be written for all patients admitted to the hospital. These records shall be filed in an orderly and accessible manner in the hospital.

(b) A minimum medical record shall contain sufficient recorded information to justify the diagnosis, verify the treatment and warrant the end results. It shall include the following information:

- (1) Identification data (name, address, age, sex, marital status);
- (2) Date of admission;
- (3) Date of discharge;
- (4) Personal and family history;
- (5) Chief complaint;
- (6) History of present illness;
- (7) Physical examination;
- (8) Special examination, if any, such as: consultations, clinical laboratory, x ray;
- (9) Provisional or admitting diagnosis;
- (10) Medical treatment (signed or initialed by person giving the medication or treatment);
- (11) The surgical record shall include: anesthesia record, pre operative diagnosis, operative procedure and findings, post operative diagnosis, and tissue diagnosis (on all specimens examined);
- (12) Progress and nurse notes;
- (13) Temperature chart including pulse and

respiration, medications;

(14) ~~Final diagnosis;~~

(15) ~~Summary and condition on discharge;~~

(16) ~~In case of death autopsy findings, if performed.~~

(c) ~~The medical record must be completed within a reasonable time after the discharge of the patient and the completion is the responsibility of the attending physician.~~

*Statutory Authority G.S. 131E-79.*

#### .1405 RETENTION OF RECORDS

All original medical records or photographs of such records shall be preserved or retained for at least the period outlined in the North Carolina Statute of Limitations and in accordance with hospital policy based on American Hospital Association recommendations and guidance of the hospital's legal advisers.

*Statutory Authority G.S. 131E-79.*

### SECTION .1500 - ACCOMMODATIONS FOR PATIENTS AND SPECIAL SERVICES

#### .1501 ROOMS

(a) ~~Each patient's room shall have an outside exposure, be dry, well ventilated and have the required window space and otherwise be suitable for occupancy.~~

(b) ~~No room shall be used for bed care of patients which can only be reached by passing through another patient's room.~~

(c) ~~Beds must be placed at least three feet apart and must be spaced so as to provide adequate room for nursing procedures and to prevent the transmission of infection.~~

(d) ~~Window Area. Window area shall be at least one eighth of the floor area.~~

(e) ~~Doors to patient rooms should be sufficiently wide to permit easy removal of the occupied bed with at least a four inch overall clearance. Vision panels should be placed in all double acting doors. Solid core doors are required so as to minimize the spread of fire.~~

(f) ~~Storage Space. There shall be suitable facilities for the safe storage of clothing, toilet articles, valuables, and other personal belongings of the patients.~~

*Statutory Authority G.S. 131E-79.*

#### .1502 ROOM FURNISHINGS

(a) ~~A separate bed mattress, pillow and bedding~~

~~shall be provided for each patient.~~

(b) ~~Gate beds or their equivalent shall be provided unless otherwise indicated by the type medical condition of the patient.~~

(c) ~~There shall be a bedside table for each patient and at least one chair in each patient room.~~

(d) ~~Effective means of signaling nurses must be provided within easy reach of all patients.~~

(e) ~~Screens or curtains shall be provided in wards or multi bedrooms in order to secure privacy for each patient. All wards or multi bedrooms shall be provided with cubicle curtains or equivalent equipment which shall completely shield the patient.~~

*Statutory Authority G.S. 131E-79.*

#### .1503 BEDSIDE EQUIPMENT

(a) ~~Individual wash basins and mouth wash cups shall be provided for each patient. This equipment shall be plainly marked for each patient, stored so that it cannot be interchanged and shall be sterilized when the patient is discharged. If individual bedpans are not provided for patients, each bedpan shall be sterilized before use by another patient.~~

(b) ~~A clinical thermometer shall be provided for each patient and shall be sterilized before each use.~~

(c) ~~Oxygen apparatus either for nasal oxygen or oxygen tents shall be provided.~~

(d) ~~A satisfactory bed lamp shall be provided for each patient's bed.~~

(e) ~~Equipment used near patients shall be adequately supported or secured and protected to avoid accident and injury.~~

*Statutory Authority G.S. 131E-79.*

#### .1504 CENTRAL SUPPLY AND STERILIZING

(a) ~~There shall be provided sufficient sterilizing supplies and equipment for all units of the hospital to ensure that asepsis is maintained in carrying out diagnostic, treatment, and personal care procedures.~~

(b) ~~Adequate cabinets, cupboards or other suitable spaces shall be provided for keeping sterile equipment and supplies in a clean, convenient and orderly manner.~~

(c) ~~All sterilization of supplies and equipment in a hospital shall be under the direct supervision of a registered nurse, or other qualified person who has received special training in this field.~~

(d) ~~Provisions shall be made for periodic inspection of all sterilizing equipment by a qualified person to ensure that equipment operates effectively.~~



y. Bacteriological methods shall be used to check sterilization processes, with at least monthly culture checks.

Statutory Authority G.S. 131E-79.

## 1505 UTILITY ROOMS

(a) Utility rooms shall have adequate lighting and ventilation. They shall be conveniently located for the efficient conduct of work.

(b) If multi purpose utility rooms are used, they shall be divided into clean and dirty areas.

(c) A bedpan hopper shall be provided in each dirty utility room area, or by water closets with bedpan flushing attachments. The bathtub, lavatory, or laundry tray shall not be used for cleaning the bedpan.

(d) Dietary items such as ice and food shall not be stored in the "dirty" utility room area.

Statutory Authority G.S. 131E-79.

## 1506 ISOLATION ROOMS

(a) There shall be available a room or rooms which shall be used for isolation of a patient or patients with communicable disease.

(b) These rooms shall be provided with hot and cold running water, soap dispenser, disposable towels, soiled towel receptacle, lavatory with other than hand controls, linen hamper, and water closet with bedpan flushing attachment.

(c) Patients with communicable diseases shall not be isolated in rooms which do not have the facilities outlined above in item number (a) of this Rule.

(d) Isolation techniques shall be in writing and filed at the nursing station and shall vary according to whether the disease is transmitted by airborne infection, food borne infection, local infection, or parasitic infection.

(e) In hospitals of 50 beds or more, at least one room shall be suitably equipped for the temporary retention and care of disturbed patients.

Statutory Authority G.S. 131E-79.

## 1507 INHALATION THERAPY

(a) Where size of the hospital and usage warrants, it is recommended that the inhalation therapy service be made a separate department. Otherwise, it shall be a full time responsibility of the nursing, central sterile supply, or anesthesia department.

(b) The administration of therapeutic agents by the aerosol route shall be under the supervision of

the inhalation therapy service.

(c) All equipment (masks, catheters, tents, regulators, etc.) shall be under the direct control of the person responsible for the inhalation therapy service.

(d) After use, all equipment shall be returned to a central location for thorough cleaning, servicing and sanitizing between patients.

Statutory Authority G.S. 131E-79.

## 1508 VISITING OF PATIENTS

(a) Each hospital shall establish policies regarding visiting for the various services and departments of the hospital. Such policies shall be in writing and posted in a prominent place.

(b) Visitors with known infectious diseases shall be excluded from visiting any patient.

Statutory Authority G.S. 131E-79.

## 1510 BED CAPACITY

(a) There shall be no more beds set up and placed into use in a hospital than the number of beds for which it is licensed to maintain except in the case of a public disaster or national, state or local emergency and then only as a temporary measure. The number of licensed beds shall be determined by the Division in accordance with standards found in this Rule.

(b) For the purpose of determining bed capacity the following square foot measurements shall apply, excluding space in toilet rooms, washrooms, closets, vestibules, and corridors:

Type of Room/Bed	Min. Sq. Ft. Per Bed
Single bed	100
Multi bed	80
Pediatric Crib	80
Pediatric Nurseries/Bassinet	40
Adult Special Care Units	120
Infant Special Care (neonatal)/Bassinet	60
Private /Rehab. Units	120
Multi bed/Rehab. Units	100

(c) The following areas shall be included in bed capacity:

- (1) bed space in all nursing units including intensive care units, special care units, and minimal or self care units;
- (2) isolation units;
- (3) pediatric units including pediatrics, bassinets and incubators and neonatal

~~units located in pediatric department;  
and~~

~~(4) observation units equipped and staffed  
for overnight use.~~

~~(d) The following areas shall be excluded from  
bed capacity:~~

~~(1) newborn nursery;~~

~~(2) labor rooms;~~

~~(3) recovery rooms;~~

~~(4) emergency units;~~

~~(5) preparation or anesthesia induction  
rooms;~~

~~(6) rooms designed and equipped for  
diagnostic and treatment purposes only;~~

~~(7) hospital staff bed areas; and~~

~~(8) unfinished space.~~

~~(e) In establishing a maximum licensed bed  
capacity for existing, occupied facilities for the  
first year following the effective date of this Rule,  
extenuating circumstances shall be considered.~~

~~(1) Bed capacity for facilities constructed  
and occupied prior to June 1, 1977,  
shall be determined by information  
gathered through an on site survey  
conducted by an authorized  
representative of the Division.~~

~~(2) Bed capacity for facilities occupied  
prior to June 1, 1977, but having  
construction projects to add beds  
underway which were not completed  
and occupied prior to June 1, 1977,  
shall be determined by information  
gathered through an on site survey  
conducted by an authorized  
representative of the Division utilizing  
plans and specifications approved by  
the Division.~~

~~(3) Bed capacity for new or replacement  
facilities constructed and occupied after  
June 1, 1977, shall be based on  
approved plans and specifications or  
certificate of need approval, whichever  
is lesser number.~~

~~(4) Single bed rooms with less than 100  
square feet floor area which were  
constructed prior to the effective date of  
this Rule shall be acceptable in  
hospitals where there are no designated  
oversized single bed rooms with a floor  
area of 160 square feet or more.  
Rooms in excess of 159 square feet  
designated as oversized single bed  
rooms prior to the effective date of this  
Rule shall remain single bed rooms and  
shall not be redesignated as multi bed~~

~~rooms without certificate of need  
approval.~~

~~(f) Bed capacity for facilities built, remodeled,  
added after the effective date of this Rule shall  
determined by the minimum standards establish  
in this Rule in conjunction with certificate of need  
approval.~~

*Statutory Authority G.S. 131-126.5.*

## SECTION .1600 - FOOD SERVICE

### .1601 FACILITIES

~~(a) The extent of compliance with  
regulations of the Division of Health Service  
pursuant to G.S. 130A in regard to sanitation  
facilities will be taken into consideration by the  
Division of Facility Services in reviewing facilities  
under this Section. In accordance with established  
policy, the Division of Health Services exchange  
information with the Division of Facility Services  
concerning its sanitation inspections.~~

~~(b) There shall be adequate facilities for the  
proper preparation and serving of food  
determined by the size and functions of the  
individual hospital. Space and equipment shall  
provided for receiving and storage, preparation  
and cooking, serving, dining, dishwashing and  
record keeping.~~

~~(c) The dietary department shall include  
facilities for the preparation of therapeutic diets.~~

~~(d) The floors of kitchens, diet kitchens, dining  
rooms, and pantries, and the floors of all rooms  
which food is stored, prepared, or served, or  
which utensils are washed, shall be of suitable  
construction as to be easily cleaned, shall be  
smooth, and shall be kept in good repair. The  
walls and ceilings of such rooms shall have a  
smooth washable surface, and shall be kept clean  
and in good repair.~~

~~(e) All rooms within the dietary department shall  
be so constructed as to prevent the entrance of rats  
and mice.~~

~~(f) All rooms in which food is stored, prepared,  
or served, and in which utensils are washed, shall  
be well lighted, provided with adequate  
ventilation, and screened against insects.~~

~~(g) Storerooms and cupboards, including shelving  
and racks, shall be constructed of easily cleanable  
smooth material, and shall be kept clean and  
orderly. The contents of such rooms and storage  
places shall be neatly stored at least 15 inches  
above the floor, and unnecessary and obsolete  
items shall not be permitted to accumulate therein.~~

~~(h) All eating, drinking, and cooking utensils~~



~~and all tables, shelves, refrigeration equipment, sinks, and other equipment or utensils used in connection with the hospital kitchen, shall be so constructed as to be easily cleaned, and shall be kept in good repair.~~

~~(i) All equipment, including shelves, tables, counters, refrigerators, stoves, hoods, sinks, meat blocks, potato peelers, grinders, slicing machines, saws, and mixers shall be kept clean and free from dust, dirt, insects, and other contaminating material.~~

~~(j) Single service articles constructed of paper fiber, such as cups, plates, straws, and caps on dietary products, shall not be re-used.~~

*Statutory Authority G.S. 131E-79.*

### **.1602 ORGANIZATION**

~~(a) The dietary department shall be under the supervision of a trained dietitian or a person skilled in the handling, preparation and serving of foods and the supervision and management of food handlers. The latter may include supervision by a contract food service.~~

~~(b) Where a qualified dietitian is not employed, the services of a qualified dietitian or nutritionist shall be secured periodically to consult with the personnel of the dietary department on food service procedures, such as the storage, processing and serving of food, the planning of menus and the management of therapeutic diets.~~

~~(c) The dietitian or person in charge of the department shall, with the approval of the administrator of the hospital, initiate policies and procedures with which each employee shall be familiar and these shall provide for the administrative and technical guidance of all personnel handling food.~~

~~(d) Records shall be kept so that comprehensive information is maintained concerning the type, quality, and the nutritional adequacy of food served to patients and personnel.~~

*Statutory Authority G.S. 131E-79.*

### **.1603 DISHWASHING PROCEDURES**

~~All dishes, knives, forks, drinking glasses, cups and other eating drinking utensils shall be thoroughly washed, rinsed, and subjected to a Division of Health Services approved bactericidal treatment after each usage. All multi purpose utensils, such as mixing bowls, cream dispensers, stock pots and baking pans shall be thoroughly cleaned and rinsed immediately after use.~~

*Statutory Authority G.S. 131E-79.*

### **.1604 FOOD SERVICE TO PATIENTS IN ISOLATION**

~~Dishes and utensils which are used by patients in isolation because of communicable disease shall be subjected to a bactericidal process before being mixed for washing with dishes and utensils used by other patients.~~

*Statutory Authority G.S. 131E-79.*

### **.1605 STORAGE AND HANDLING OF FOOD**

~~(a) All food shall be stored, handled, and served as to be protected from dust, flies, rats, vermin, handling, droplet infection, overhead leakage, and other contamination.~~

~~(b) All means necessary for the elimination of flies and roaches shall be used.~~

~~(c) All readily perishable food or drink shall be kept at or below 50 degrees F., except when being prepared or served. All fresh meats, except in small portions for immediate use, shall be stored at or below 40 degrees F.~~

~~(d) Grade "A" milk products shall be used. These products shall be served in the original containers in which they are received from the distributor, so that the name and grade of the contents, and the name of the producer or distributor, may be readily observed by the patient. This requirement shall not apply to buttermilk which is used strictly for cooking purposes only.~~

~~(e) Milk products shall be stored in a sanitary manner and shall be kept refrigerated except when being served. Containers shall not be completely submerged in water.~~

~~(f) All food shall be wholesome and free from spoilage. Food that is spoiled or unfit for human consumption shall not be kept on the premises.~~

~~(g) Portions of food once served to patients, or employees, shall not be served again.~~

*Statutory Authority G.S. 131E-79.*

### **.1606 EMPLOYEES**

~~(a) All employees shall be free of communicable and infectious disease, as defined in G.S. 130A-133, as it applies in each work assignment.~~

~~(b) It shall be the responsibility of the management to require such inspections and tests as often as are necessary to safeguard the health of the patient and other employees.~~

~~(c) All employees shall wear clean outer~~

garments, and shall keep their hands clean at all times when handling food, drink, utensils, or equipment.

(d) ~~Female dietary employees must wear hairnets and male dietary employees must wear caps.~~

(e) ~~Kitchen employees shall not use tobacco in any form while engaged in food handling operations.~~

*Statutory Authority G.S. 131E-79.*

## SECTION .1700 - PHYSICAL PLANT

### .1701 MAINTENANCE

(a) ~~The hospital structure and component parts and facilities shall be kept in good repair and maintained with consideration for the safety and comfort of the patient.~~

(b) ~~There shall be a definite assignment of maintenance functions to qualified personnel under supervision.~~

*Statutory Authority G.S. 131E-79.*

### .1702 HEATING

(a) ~~Heating plants shall be adequate to maintain a cold weather temperature of 70 degrees F. in all rooms used by patients.~~

(b) ~~All boilers must meet requirements of the North Carolina Department of Labor. Current certificates of compliance must be properly displayed.~~

*Statutory Authority G.S. 131E-79.*

### .1703 ARTIFICIAL LIGHTING

(a) ~~Each patient room shall have sufficient lighting to allow the physician and nursing personnel to examine and treat the patient. This shall be no less than 50 foot candles 36 inches above the floor.~~

(b) ~~Every room, including storerooms, hallways, and others shall have sufficient artificial light to make all parts clearly visible and to permit efficient performance of all necessary work. This shall be no less than 15 foot candles at floor level.~~

(c) ~~All hallways, stairways, inclines, ramps, and entrances shall be well lighted. This shall be no less than 15 foot candles at floor level.~~

*Statutory Authority G.S. 131E-79.*

### .1704 EMERGENCY ELECTRICAL

## SERVICE

(a) ~~Emergency electric service is required. This may be met by one or a combination of the following methods:~~

(1) ~~a generating plant other than that supplying the main service, provided the respective transmission lines are widely separated;~~

(2) ~~an emergency generator on the hospital site;~~

(3) ~~rechargeable storage batteries.~~

(b) ~~The emergency services should be so arranged that in the event of interruption of normal service, the emergency system will be automatically placed in operation. Automatic switching equipment must be of a type and so interlocked as not to permit both normal and emergency services being connected together through any operation of the automatic switching equipment.~~

(c) ~~As a minimum, the following facilities should be served:~~

(1) ~~lighting for operating, emergency and delivery rooms, exits and exit direction signs, corridors, stairways, nurseries, recovery room, telephone switchboard and boiler room;~~

(2) ~~nurses' call system, fire alarm system, incubators, respirators, and refrigerators for medical supplies, bone, blood and biologicals;~~

(3) ~~heating plant;~~

(4) ~~convenience outlets in operating rooms, emergency rooms, delivery rooms, recovery rooms, nurseries, and one or more outlets on each nursing unit.~~

(d) ~~Emergency electrical services shall be furnished in accordance with current applicable sections of the North Carolina State Building Code and National Fire Protection Association Codes which are hereby adopted by reference pursuant to G.S. 150B-14(e).~~

*Statutory Authority G.S. 131E-79.*

### .1705 GROUNDING SYSTEM

~~A properly designed equipment grounding system as well as an isolated from ground and detector monitored electrical source are essential to patient safety and must be installed in areas where electronic equipment for coronary patients is used.~~

*Statutory Authority G.S. 131E-79.*

### .1706 VENTILATION



(a) ~~Each patient's room shall have at least one window, opening to the outside to permit ventilation and a source of natural light.~~

(b) ~~Kitchens, morgues, bathrooms, and service rooms shall be located and ventilated by window or mechanical devices to prevent offensive odors from entering patients' rooms and public halls.~~

(c) ~~Rooms used for the storage of flammable or non-flammable anesthetics and rooms where flammable and non-flammable anesthetics are administered shall be provided with ventilation in accordance with the current applicable sections of the North Carolina State Building Code and the National Fire Protection Association Codes which are hereby adopted by reference pursuant to G.S. 150B-14(e).~~

(d) ~~A mechanical air supply system shall be provided for year round usage in operating and delivery rooms.~~

*Statutory Authority G.S. 131E-79.*

#### 1707 STAIRWAYS AND ELEVATORS

(a) ~~Stairways shall be of a width and design which will easily accommodate removal of a patient by stretcher and meet the requirements of the State Insurance Department.~~

(b) ~~Hospitals which have accommodations for patients above the first floor shall have an adequate number of elevators servicing patient areas.~~

(c) ~~Elevators and machinery shall be so constructed and maintained as to comply with the regulations of the North Carolina Department of Labor.~~

*Statutory Authority G.S. 131E-79.*

#### 1708 WATER SUPPLY

(a) ~~The water shall be obtained from a municipal water supply or a private supply system, the location, construction, and operation of which will comply with the standards of the North Carolina Division of Health Services.~~

(b) ~~The water shall be distributed to conveniently located taps and fixtures in the building.~~

(c) ~~There shall be an ample supply of hot water available at all times for general use.~~

(d) ~~All dietary ice shall be stored, handled, and served in a sanitary manner. Ice storage boxes, ice scoops, buckets and containers shall be maintained in good repair and kept clean. Ice scoops, buckets, containers, etc., shall be stored so as not to be subject to contamination. Ice boxes shall be covered.~~

(e) ~~Dietary ice shall not be stored in the dirty utility room.~~

(f) ~~Dietary ice shall be stored and transported only in covered containers.~~

*Statutory Authority G.S. 131E-79.*

#### .1709 SEWAGE DISPOSAL

~~Solid and liquid waste shall be disposed of in accordance with the sanitation rules for hospitals contained in 10 NCAC 10A which are hereby adopted by reference pursuant to G.S. 150B-14(e).~~

*Statutory Authority G.S. 131E-79.*

#### .1710 PLUMBING

(a) ~~All plumbing installed must be in accordance with the North Carolina Building Code.~~

(b) ~~All plumbing facilities, whether for sterilization of utensils, instruments or supplies, general water supply or waste disposals, shall be installed in such a manner as to completely prevent possibility of cross connections between safe and unsafe supplies or back siphonage.~~

(c) ~~A toilet room shall be directly accessible from each patient room and from each central bathing area without going through the general corridor. One toilet room may serve two patient rooms but not more than eight beds. The lavatory may be omitted from the toilet room if one is provided in each patient's room.~~

(d) ~~One tub or shower shall be provided for each 15 beds not individually served. There shall be at least one bathtub accessible on three sides and one shower provided for each 60 beds or fraction thereof.~~

*Statutory Authority G.S. 131E-79.*

#### .1711 GARBAGE AND TRASH DISPOSAL

(a) ~~All garbage shall be handled and disposed of in accordance with the current minimum standards established by the Division of Environmental Health.~~

(b) ~~All trash shall be kept in suitable receptacles and stored in a room designed for trash storage to meet the current minimum applicable standards established by the North Carolina State Building Code. Trash accumulated during any one working shift, in each department, shall be collected at the end of that shift and stored in approved trash room(s).~~

*Statutory Authority G.S. 131E-79.*

### .1712 INCINERATION

(a) ~~Incineration facilities shall be provided for disposal of infectious waste in accordance with Solid Waste Management Rules 10 NCAC 10G which are hereby adopted by reference pursuant to G.S. 150B-146.~~

(b) ~~Infectious waste that is not incinerated shall be sterilized before being placed in a general waste disposal system in accordance with Solid Waste Management Rules 10 NCAC 10G.~~

*Statutory Authority G.S. 131E-79.*

### .1713 SCREENS

~~All outside doors, windows and other openings shall have effective protective measures against mosquitoes, flies, and other insects. All screen doors shall open outward and be equipped with self-closing devices.~~

*Statutory Authority G.S. 131E-79.*

### .1714 HAND WASHING

(a) ~~There shall be adequate hand washing facilities within or conveniently located with regard to every patient's room or patient caring service.~~

(b) ~~Hand scrubbing sinks shall be provided in surgical and obstetrical suites, labor rooms, nurseries, examining and treatment rooms, and in rooms used in the isolation of patients.~~

(c) ~~Hand washing facilities must be provided for food handlers and other hospital employees. Notices prescribing the washing of hands after contamination shall be prominently posted in toilets, washrooms, and all food stations.~~

*Statutory Authority G.S. 131E-79.*

### .1715 HOUSEKEEPING

(a) ~~Housekeeping facilities and services are required to be such that comfortable and sanitary living conditions for patients and employees are maintained constantly.~~

(b) ~~There shall be an adequate number of janitor's closets with mop receptors convenient to all areas. Storage of janitorial equipment and supplies shall be provided for in these closets. Surgical and obstetrical suites shall have their own janitor's closets and cleaning equipment.~~

(c) ~~There must be frequent cleaning of the floors, walls, woodwork, and windows. Dusting, sweeping, and vacuum cleaning shall be performed in such a manner as to minimize the spread of dust particles in the hospital atmosphere. Accumulated~~

~~waste material must be removed at least daily.~~

(d) ~~The premises must be kept free from rodents and insect infestation.~~

(e) ~~Bath and toilet facilities must be maintained in a clean and sanitary condition at all times.~~

(f) ~~Written procedures should be available to housekeeping personnel.~~

*Statutory Authority G.S. 131E-79.*

### .1716 LINEN

(a) ~~A supply of towels, washcloths, bath blankets, and all other linen which comes directly in contact with the patient shall be provided as needed for each individual patient. No such linen shall be interchangeable from one patient to another before being properly cleaned and laundered.~~

(b) ~~Bedpan covers shall not be used interchangeably.~~

(c) ~~There shall be a supply of clean linens to assure the cleanliness and safety of the patients. Particular attention must be given to assuring supply of clean linens during and after weekends, holidays, and other periods when the laundry is not in operation.~~

(d) ~~There shall be distinct separate areas for the storage and handling of clean and dirty linens.~~

(e) ~~Equipment used to transport dirty linens shall not be used to transport clean linens. All linen shall be covered during transportation.~~

(f) ~~All dirty linen hampers shall be kept covered.~~

*Statutory Authority G.S. 131E-79.*

### .1717 LAUNDRY

(a) ~~The institution shall make provision for proper cleaning of linen and other washable goods with special provision for handling contaminated linen.~~

(b) ~~Hospitals operating their own laundries shall provide ventilation for the elimination of steam and odors and proper insulation to prevent the transportation of noise to patient areas.~~

(c) ~~Where linen is sent to an outside laundry the administrator shall assure that proper facilities are available and methods for handling and cleaning the hospital linen are used as provided for in Paragraph (a) of this Rule.~~

*Statutory Authority G.S. 131E-79.*

## SECTION .1800 - FIRE REGULATIONS



## 1801 STANDARDS

(a) ~~Fire protection standards shall be in accordance with the North Carolina State Building Code which is hereby adopted by reference pursuant to G.S. 150B-14(e). In addition, they shall be in accordance with current applicable standards of the National Fire Protection Association Codes, which are hereby adopted by reference pursuant to G.S. 150B-14(e) for:~~

- (1) ~~Installation, maintenance, and use of fire extinguishers;~~
- (2) ~~Use of flammable anesthetics; and~~
- (3) ~~Use of non flammable anesthetics.~~

(b) ~~In addition, state and local fire laws shall be complied with.~~

*Statutory Authority G.S. 131E-79.*

## 1802 MASTER PLAN AND FIRE DRILLS

(a) ~~Each institution shall develop a master fire plan to fit the needs of the hospital.~~

(b) ~~Employees shall be trained in the use of fire fighting equipment, and in the means of rapidly evacuating the building by staff fire drills.~~

(c) ~~Drills shall be held quarterly and at varied hours.~~

(d) ~~A written record of each drill shall be kept on file for a period of one year.~~

*Statutory Authority G.S. 131E-79.*

## 1803 EXITS

~~There shall be alternate exits, meeting the following specifications from all occupied floors:~~

- (1) ~~a safe continuous exit from the interior of a building to a street or other open spaces at grade level connected to a street;~~
- (2) ~~remote location from other exits so that each exit is readily accessible and visible and arranged so that there are no pockets or dead ends, and no exits concealed nor the direction to the exit obscured by mirrors, draperies or other objects;~~
- (3) ~~exits maintained so as to provide free and unobstructed egress from all parts of the buildings with no locks or fastenings installed on exit doors which may potentially prevent immediate egress from the inside of a building or structure;~~
- (4) ~~exits plainly marked with directions to a designated termination at a place of safety, and exit signs illuminated either externally or internally.~~

*Statutory Authority G.S. 131E-79.*

## 1804 TRASH CHUTES

(a) ~~The use of trash chutes is not recommended, but when used they must be installed in adequate two hour rated fire resistive shafts and provided with suitably labeled fire doors at each access opening into the chute. In addition, the access door at each floor should be located in an anteroom or vestibule off the corridor so that it is readily cut off from the rest of the floor. The door from corridor to anteroom or vestibule must be a two hour rated door. The top of the chute must extend full size through the roof to the outdoors since, in case of fire in the chute, it must perform as a chimney. The top of the chute should be roofed with a metal hood. The chute should also be provided with an automatic sprinkler head. The trash chute room must have enclosures of two hour rated construction including a two hour rated door.~~

(b) ~~For existing hospitals, the use of all trash chutes not installed in the above manner shall be discontinued, cleaned, sealed and secured to prevent any possible use.~~

*Statutory Authority G.S. 131E-79.*

## 1805 LINEN CHUTES

~~Linen chutes must be installed in adequate two hour rated fire resistive shafts and provided with suitably labeled fire doors at each access opening to the chute. The top of the chute must extend full size through the roof to the outdoors since, in case of fire in the chute, it must perform as a chimney. The top of the chute must be roofed with a metal hood. The chute must also have flushing ring with water valve accessible in the soiled linen room, and also have an automatic sprinkler head. The soiled linen room must be of two hour rated construction and have a two hour rated door.~~

*Statutory Authority G.S. 131E-79.*

## SECTION 1900 - SUPPLEMENTAL RULES FOR THE LICENSURE OF THE SKILLED:INTERMEDIATE: DOMICILIARY BEDS IN A HOSPITAL

### 1901 SUPPLEMENTAL RULES

~~When a hospital offers nursing facility or domiciliary home long term care services, the services shall be included under one hospital license as provided in Rule .0201(e). The general~~

requirements included in this Subchapter shall apply when applicable but in addition the nursing facility care and domiciliary home care unit must meet the supplemental requirements of this Section.

Authority G.S. 131E-79; 42 U.S.C. 1396 r (a).

## 1902 DEFINITIONS

The following definitions shall apply throughout this Section, unless text otherwise clearly indicates to the contrary:

- (1) "Accident" means something occurring by chance or without intention which has caused physical or mental harm to a patient, resident or employee.
- (2) "Administer" means the direct application of a drug to the body of a patient by injection, inhalation, ingestion or other means.
- (3) "Administrator" means the person who has authority for and is responsible to the governing board for the overall operation of a facility.
- (4) "Brain injury long term care" is defined as an interdisciplinary, intensive maintenance program for patients who have incurred brain damage caused by external physical trauma and who have completed a primary course of rehabilitative treatment and have reached a point of no gain or progress for more than three consecutive months. Services are provided through a medically supervised interdisciplinary process and are directed toward maintaining the individual at the optimal level of physical, cognitive and behavioral functioning.
- (5) "Capacity" means the maximum number of patient or resident beds which the facility is licensed to maintain at any given time. This number shall be determined as follows:
  - (a) Bedrooms shall have minimum square footage of 100 square feet for a single bedroom and 80 square feet per patient or resident in multi-bedded rooms. This minimum square footage shall not include space in toilet rooms, washrooms, closets, vestibules, corridors, and built in furniture.
  - (b) Dining, recreation and common use areas available shall total no less than 25 square feet per bed for skilled

nursing and intermediate care beds and no less than 30 square feet per bed for domiciliary home beds. Such space must be contiguous to patient and resident bedrooms.

- (6) "Combination Facility" means a hospital with nursing home beds which is licensed to provide more than one level of care such as a combination of intermediate care and/or skilled nursing care and domiciliary home care.
- (7) "Convalescent Care" means care given for the purpose of assisting the patient or resident to regain health or strength.
- (8) "Department" means the North Carolina Department of Human Resources.
- (9) "Director of Nursing" means the nurse who has authority and direct responsibility for all nursing services and nursing care.
- (10) "Dispense" means preparing and packaging a prescription drug or device in a container and labeling the container with information required by state and federal law. Filling or refilling drug containers with prescription drugs for subsequent use by a patient is "dispensing". Providing quantities of unit dose prescription drugs for subsequent administration is "dispensing".
- (11) "Drug" means substances:
  - (a) recognized in the official United States Pharmacopoeia, official National Formulary, or any supplement to any of them;
  - (b) intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals;
  - (c) intended to affect the structure or any function of the body of man or other animals, i.e., substances other than food; and
  - (d) intended for use as a component of any article specified in (a), (b), or (c) of this Subparagraph; but does not include devices or their components, parts, or accessories.
- (12) "Duly Licensed" means holding a current and valid license as required under the General Statutes of North Carolina.
- (13) "Existing Facility" means a licensed facility; or a proposed facility, proposed addition to a licensed facility or proposed remodeled licensed facility that will be



built according to plans and specifications which have been approved by the department through the preliminary working drawings stage prior to the effective date of this Rule.

- (14) "Exit Conference" means the conference held at the end of a survey, inspection or investigation, but prior to finalizing the same, between the department's representatives who conducted the survey, inspection or investigation and the facility administration representative(s).
- (15) "Incident" means an intentional or unintentional action, occurrence or happening which is likely to cause or lead to physical or mental harm to a patient, resident or employee.
- (16) "Licensed Practical Nurse" means a nurse who is duly licensed as a practical nurse under G.S. 90, Article 9A.
- (17) "Licensee" means the person, firm, partnership, association, corporation or organization to whom a license has been issued.
- (18) "Medication" means drug as defined in (12) of this Rule.
- (19) "New Facility" means a proposed facility, a proposed addition to an existing facility or a proposed remodeled portion of an existing facility that is constructed according to plans and specifications approved by the department subsequent to the effective date of this Rule. If determined by the department that more than one half of an existing facility is remodeled, the entire existing facility shall be considered a new facility.
- (20) "Nurse Aide" means any individual providing nursing or nursing related services to patients in a facility, and is not a licensed health professional, a qualified dietitian or someone who volunteers to provide such services without pay, and who is listed in a nurse aide registry approved by the Department.
- (21) "Nurse Aide Trainee" means an individual who has not completed an approved nurse aide training course and competency evaluation and is demonstrating knowledge, while performing tasks for which they have been found proficient by an instructor. These tasks shall be performed under the

direct supervision of a registered nurse. The term does not apply to volunteers.

- (22) "Nursing Facility" means that portion of a nursing home certified under Title XIX of the Social Security Act (Medicaid) as in compliance with federal program standards for nursing facilities. It is often used as synonymous with the term "nursing home" which is the usual prerequisite level for state licensure for nursing facility (NF) certification and Medicare skilled nursing facility (SNF) certification.
- (23) "Nurse in Charge" means the nurse to whom duties for a specified number of patients and staff for a specified period of time have been delegated, such as for Unit A on the 7-3 or 3-11 shift.
- (24) "On Duty" means personnel who are awake, dressed, responsive to patient needs and physically present in the facility performing assigned duties.
- (25) "Patient" means any person admitted for care to a skilled nursing or intermediate care facility.
- (26) "Physician" means a person licensed under G.S. Chapter 90, Article 1 to practice medicine in North Carolina.
- (27) "Qualified Dietitian" means a person who meets the standards and qualifications established by the Committee on Professional Registration of the American Dietetic Association included in "Standards of Practice" seven dollars and twenty five cents (\$7.25) or "Code of Ethics for the Profession of Dietetics" two dollars and fifteen cents (\$2.15); American Dietetic Association, 216 W. Jackson Blvd., Chicago, IL 60606-6995.
- (28) "Registered Nurse" means a nurse who is duly licensed as a registered nurse under G.S. 90, Article 9A.
- (29) "Resident" means any person admitted for care to a domiciliary home.
- (30) "Sitter" means an individual employed to provide companionship and social interaction to a particular resident or patient, usually on a private duty basis.
- (31) "Supervisor in Charge" means a duly licensed nurse to whom supervisory duties have been delegated by the Director of Nursing.
- (32) "Ventilator dependence" means physiological dependency by a patient on the use of a ventilator for more than eight

hours-a-day.

Statutory Authority G.S. 131E-79.

### .1903 INSPECTIONS

(a) ~~Any hospital with beds licensed by the Department under Section 1900 of these Rules may be inspected by one or more authorized representatives of the Department at any time. Generally, inspections will be conducted between the hours of 8:00 a.m. and 6:00 p.m., Monday through Friday. However, complaint investigations shall be conducted at the most appropriate time for investigating allegations of the complaint.~~

(b) ~~At the time of inspection, any authorized representative of the Department shall make his presence known to the administrator or other person in charge who shall cooperate with such representative and facilitate the inspection.~~

Authority G.S. 131E-79; 42 U.S.C. 1396 r (a).

### .1904 PROCEDURE FOR APPEAL

~~A hospital with nursing facility or domiciliary home beds may appeal any decision of the Department to deny, revoke or alter a license by making such an appeal in accordance with G.S. Chapter 150B.~~

Authority G.S. 131E-79; 42 U.S.C. 1396 r (a).

### .1905 ADMISSIONS

(a) ~~No patient shall be admitted except under the orders of a duly licensed physician.~~

(b) ~~The facility shall acquire prior to or at the time of admission orders from the attending physician for the immediate care of the patient or resident.~~

(c) ~~Within 48 hours of admission, the facility shall acquire medical information which shall include current medical findings, diagnosis, rehabilitation potential, a summary of the hospital stay if the patient is being transferred from a hospital, and orders for the ongoing care of the patient.~~

(d) ~~If a patient is admitted from somewhere other than a hospital, a physical examination shall be performed either within 5 days prior to admission or within 48 hours following admission.~~

(e) ~~Hospitals offering nursing facility or domiciliary home care as a new service must prepare a plan of admission which, at a minimum, assures availability of staff time and plans for individual patient assessments, initiation of health~~

~~care or nursing care plans, and implementation of physician and nursing treatment plans. This plan must be available for inspection during the initial licensure survey prior to issuance of a license.~~

(f) ~~Only persons who are 18 years of age or older shall be admitted to domiciliary home beds in a facility.~~

Authority G.S. 131E-79; 42 U.S.C. 1396 r (a).

### .1906 POLICIES AND PROCEDURES

~~The governing board shall assure written policies and procedures which are available to and implemented by staff. These policies and procedures shall cover at least the following areas:~~

- (1) ~~admissions;~~
- (2) ~~dietary;~~
- (3) ~~discharges with physician orders and patients or residents leaving against physician advice;~~
- (4) ~~gratuities and solicitation which at a minimum shall provide that no owner, operator, agent or employee of a facility nor any member of his family shall accept a gratuity directly or indirectly from an patient or resident in the facility or solicit for any type of contribution;~~
- (5) ~~housekeeping;~~
- (6) ~~infection control which must include, but shall not be limited to, requirements for sterile, aseptic and isolation techniques and communicable disease screening, including, at a minimum, annual tuberculosis screening for all staff and inpatients of the facility;~~
- (7) ~~maintenance of patient medical or health care records including charging or record keeping;~~
- (8) ~~orientation of all facility personnel;~~
- (9) ~~patient or resident care plans, treatment and other health care or nursing care including but not limited to all policies and procedures required by rules contained in this Subchapter;~~
- (10) ~~patients' or residents' rights;~~
- (11) ~~physical evaluation for residents and patients at least annually;~~
- (12) ~~physician services and utilization of the individual's private physician;~~
- (13) ~~procurement of supplies and equipment to meet individual patient care needs;~~
- (14) ~~protection of patients from abuse and neglect;~~
- (15) ~~range of services provided;~~
- (16) ~~recording and reporting to the department~~



~~of accidents or incidents occurring to patients in any part of the facility and maintenance of such reports or records;~~

- ~~(17) rehabilitation services;~~
- ~~(18) release of medical record information;~~
- ~~(19) screening and reporting communicable disease to the local health department; and~~
- ~~(20) transfers.~~

*Statutory Authority G.S. 131E-79.*

## 1907 GENERAL

~~The governing board shall assure that policies and procedures are available and implemented for assessing each patient's or resident's health care needs and planning for meeting identified health care needs. There shall be a system for evaluating the effectiveness of the assessment, planning and implementation (delivery of care processes) for each patient or resident.~~

*Statutory Authority G.S. 131E-79.*

## 1908 FREQUENCY: METHOD AND CONTENT OF ASSESSMENT: PLANNING

~~Each patient's and resident's condition must be assessed on a regular, periodic basis, at least quarterly, with appropriate notation and updating of the health care plan. Health care planning for each patient and resident shall be an on-going process and must include, but shall not be limited to, the following:~~

- ~~(1) data which is systematically and continuously collected about his or her health status; the data shall be recorded so as to be accessible and communicated to all staff involved in the patient's or resident's care;~~
- ~~(2) current problems or needs identified and prioritized from a completed assessment relevant to the patient's or resident's response to aging, illness and general health status; and~~
- ~~(3) a current plan of care developed in conjunction with the patient or resident or legal guardian that includes measurable time related goals and approaches, or measures to be employed by various disciplines in order to achieve the identified goals.~~

*Statutory Authority G.S. 131E-79.*

## .1909 IMPLEMENTATION OF HEALTH PLAN

~~All parts of the plan of care shall be assigned to specific disciplines or staff as indicated in the plan of care to assure that health care and rehabilitative services are performed daily and documented for those patients and residents who require such services.~~

*Statutory Authority G.S. 131E-79.*

## .1910 NURSING/HEALTH CARE ADMINISTRATION AND SUPERVISION

~~(a) A licensed facility shall have a director of nursing service who shall be responsible for the overall organization and management of all nursing services and shall be currently licensed to practice as a registered nurse by the North Carolina Board of Nursing in accordance with G.S. 90, Article 9A.~~

~~(b) The Director of Nursing shall not serve as administrator or assistant administrator.~~

~~(c) A licensed facility with nursing facilities shall provide a full time director of nursing on duty at least eight hours per day, five days a week. A registered nurse shall relieve the Director of Nursing (be in charge of nursing) during the Director's absence.~~

~~(d) A licensed facility shall employ and assign registered nurses, licensed practical nurses, nurse aides and nurse aide trainees for duties in accordance with G.S. 90, Article 9A.~~

~~(e) The Director of Nursing shall cause the following to be accomplished:~~

- ~~(1) establishment and implementation of nursing policies and procedures which shall include, but shall not be limited to the following:~~
  - ~~(A) assessment of and planning for patients' nursing care or health care needs, and implementation of nursing or health care plans;~~
  - ~~(B) daily charting of any unusual occurrences or acute episodes related to patient care, and progress notes written monthly reporting each patient's performance in accordance with identified goals and objectives and each patient's progress toward rehabilitative nursing goals;~~
  - ~~(C) assurance of the delivery of nursing services in accordance with physicians' orders, nursing care plans and the facility's policies and~~

- procedures;
- (D) ~~notification of emergency physicians or on-call physicians;~~
- (E) ~~infection control to prevent cross infection among patients and staff;~~
- (F) ~~reporting of deaths;~~
- (G) ~~emergency reporting of fire, patient and staff accidents or incidents, or other emergency situations;~~
- (H) ~~use of protective devices or restraints to assure that each patient or resident is restrained in accordance with physician orders and the facility's policies, and that the restrained patient or resident is appropriately evaluated and released at a minimum of every two hours;~~
- (I) ~~special skin care and decubiti care;~~
- (J) ~~bowel and bladder training;~~
- (K) ~~maintenance of proper body alignment and restorative nursing care;~~
- (L) ~~supervision of and assisting patients with feeding;~~
- (M) ~~intake and output observation and reporting for those patients whose condition warrants monitoring of their fluid balance. This will include those patients on intravenous fluids or tube feedings, and patients with kidney failure and temperatures elevated to 102 degrees Fahrenheit or above;~~
- (N) ~~catheter care; and~~
- (O) ~~procedures used in caring for patients in the facility;~~
- (2) ~~development of written job descriptions for nursing personnel;~~
- (3) ~~periodic assessment of the nursing department with identification of personnel requirements as they relate to patient care needs and reporting same to the administrator;~~
- (4) ~~a planned orientation and continuing inservice education program for nursing employees and documentation of staff attendance and subject matter covered during inservice education programs;~~
- (5) ~~provision of appropriate reference materials for the nursing department, which includes a Physician's Desk Reference or comparable drug reference, policy and procedure manual, and medical dictionary for each nursing station; and~~
- (6) ~~establishment of operational procedures~~

~~to assure that appropriate supplies and equipment are available to nursing staff as determined by individual patient care needs.~~

Authority G.S. 131E-79; 42 U.S.C. 1396 r (a).

#### .1911 VACANT DIRECTOR OF NURSING POSITION

(a) ~~The administrator shall notify the Department within 72 hours when the director of nursing position becomes vacant and shall provide the name and license number of the individual who is acting director or the replacement for the director of nursing.~~

(b) ~~A facility shall not operate without either a director of nursing or acting director of nursing.~~

(c) ~~The administrator shall employ a director of nursing within 30 days after a position becomes vacant. A vacancy which exceeds 30 days shall be reviewed by the Department for action relative to licensure status of the facility.~~

Statutory Authority G.S. 131E-79.

#### .1912 NURSE STAFFING REQUIREMENTS

(a) ~~A licensed facility shall provide licensed nursing personnel sufficient to accomplish the following:~~

- (1) ~~patient needs assessment;~~
- (2) ~~patient care planning; and~~
- (3) ~~supervisory functions in accordance with the level of patient or resident care advertised or offered by the facility.~~

~~The facility also shall provide other nursing personnel sufficient to assure that at least activities of daily living, personal grooming, restorative nursing actions and other health care needs as identified in each patient's or resident's plan of care are met.~~

(b) ~~A licensed multi storied facility (one having more than one story) shall provide at least one person on duty on each patient care floor at all times.~~

(c) ~~Daily direct patient care nursing staff, licensed and unlicensed, shall equal or exceed 2.1 nursing hours per patient. (This is sometimes referred to as nursing hours per patient day or NHPPD or NH/PD.)~~

- (1) ~~Inclusive in these figures is the requirement that at least one licensed nurse is on duty for direct patient care at all time; and~~
- (2) ~~Nursing care shall include the services of a registered nurse for at least eight~~



consecutive hours a day, seven days a week. This coverage can be spread over more than one shift if such a need exists. The Director of Nursing may be counted as meeting the requirements for both the Director of Nursing and patient and resident care staffing for facilities of a total census of 60 beds or less.

(d) Nursing support personnel including ward clerks, secretaries, nurse educators and persons in primarily administrative management positions and not actively involved in direct patient care shall not be counted toward compliance with minimum staffing requirements for direct care staffing.

(e) All exceptions to meeting minimum staffing requirements shall be reported to the Department at the end of each month. Staffing waivers granted by the federal government for Medicare and Medicaid certified beds shall be accepted for licensure purposes.

(f) The ratio of male to female nurse aides will be determined by the needs of the patients, particularly the numbers of male patients requiring assistance with personal care.

Authority G.S. 131E-79; 42 U.S.C. 1396 r (a)(4)(C).

## 1915 DOMICILIARY HOME PERSONNEL REQUIREMENTS

(a) The administrator shall designate a person to be in charge of the domiciliary home residents at all times. The nurse in charge of nursing services may also serve as supervisor in charge of the domiciliary home beds.

(b) If domiciliary home beds are located in a separate building or a separate level of the same building, there must be a person on duty in the domiciliary home areas at all times.

(c) A licensed facility shall provide sufficient staff to assure that activities of daily living, personal grooming, and assistance with eating are provided to each resident. Medication administration as indicated by each resident's condition or physician's orders shall be carried out as identified in each resident's plan of care.

(d) Domiciliary home facilities (Home for the aged beds) licensed as a part of a combination facility shall comply with the staffing requirements of 10 NCAC 42D .1407 as adopted by the Social Services Commission for freestanding domiciliary homes.

Statutory Authority G.S. 131E-79; 42 U.S.C. 1396

r (a).

## 1916 REHABILITATIVE NURSING AND DECUBITUS CARE

Each patient or resident shall be given care to prevent contractures, deformities, and decubiti, including but not limited to:

- (1) changing positions of bedfast and chairfast patients or residents every two hours and administering simple preventive care. Documentation of such care and outcome must be included in routine summaries or progress notes;
- (2) maintaining proper alignment and joint movement to prevent contractures and deformities, which must be documented in routine summaries or progress notes;
- (3) implementing an individualized bowel and bladder training program except for patients or residents whose records are documented that such training is not effective. A monthly summary for patients and quarterly summaries for domiciliary residents shall be written relative to each patient's or resident's performance in the bowel and bladder training program; and
- (4) such other services as necessary to meet the needs of the patient.

Authority G.S. 131E-79; 42 U.S.C. 1396 r (a).

## 1917 MEDICATION ADMINISTRATION

(a) A licensed facility shall have policies and procedures governing the administration of medications which shall be enforced and implemented by administration and staff. Policies and procedures shall include, but shall not be limited to:

- (1) automatic stop orders for treatment and drugs;
- (2) accountability of controlled substances as defined by the North Carolina Controlled Substances Act, G.S. 90, Article 5;
- (3) dispensing and administering behavior modifying drugs, such as hypnotics, sedatives, tranquilizers, antidepressants and other psychotherapeutic agents; insulin; intravenous fluids and medications; cardiovascular regulating drugs; and antibiotics.

(b) All medications or drugs and treatments shall be administered and discontinued in accordance with signed physician's orders which are recorded

in the patient's or resident's medical record.

- (1) Only physicians, registered nurses, licensed practical nurses or physician assistants, if in accordance with the assistant's approved practice, shall administer medications.
- (2) To ensure accountability, any medication shall be administered by the same licensed personnel who prepared the dose for administration. This Rule does not apply to the dispensing of medications from a pharmacy utilizing a unit-of-use drug delivery system.
- (3) Medications shall be administered within a half hour prior to or half hour after the prescribed time for administration unless precluded by emergency situations.
- (4) The person administering medications shall identify each patient or resident in accordance with the facility's policies and procedures prior to administering any medication.
- (5) Medication administered to a patient or resident shall be recorded in the patient's or resident's medication administration record immediately after administration in accordance with the facility's policies and procedures.
- (6) Omission of medication and the reason for the omission shall be indicated in the patient's or resident's medical record.
- (7) The person administering medications which are ordered to be given as needed (PRN) shall justify the need for the same in the patient's or resident's medical record.
- (8) Medication administration records shall provide identification of the drug and strength of drug, quantity of drug administered, name of administering employee, title of employee and time of administration.

(c) Self administration of medications shall be permitted only if prescribed by a physician and directions are printed on the container.

(d) The administration of one patient's or resident's medications to another patient or resident is prohibited except in the case of an emergency. In the event of such an emergency, steps shall be taken to assure that the borrowed medications shall be replaced promptly and so documented.

(e) Verbal orders shall be countersigned by a

physician within five days of issuance.

Statutory Authority G.S. 131E-79.

## 1918 TRAINING

(a) A licensed facility shall provide for a patient or resident care employees a planned orientation and continuing education program emphasizing patient or resident assessment and planning, activities of daily living, personal grooming, rehabilitative nursing or restorative care, other patient or resident care policies and procedures, patients' rights, and staff performance expectations. Attendance and subject matter covered shall be documented for each session and available for licensure inspections.

(b) The administrator shall assure that each employee is oriented within the first week of employment to the facility's philosophy and goals.

(c) Each employee shall have specific on-the-job training as necessary for the employee to properly perform his individual job assignment.

(d) Unless otherwise prohibited, a nurse aide trainee may be employed to perform the duties of a nurse aide for a period of time not to exceed four months. During this period of time the nurse aide trainee shall be permitted to perform only those tasks for which minimum acceptable competence has been demonstrated and documented on a skills check off record. Job applicants for nurse aide positions who were formerly qualified nurse aides but have not been gainfully employed as such for a period of 2 consecutive months or more shall be employed only as nurse aide trainees and must re-qualify as nurse aides within four months of hire by successfully passing an approved competency evaluation. Any individual, nursing home, or education facility may offer Department approved vocational education for nursing home nurse aides. An accurate record of nurse aide qualification shall be maintained for each nurse aide used by facility and shall be retained in the general personnel files of the facility.

(e) The curriculum content required for nurse aide education programs shall be subject to approval by the Division of Facility Services and shall include, as a minimum, basic nursing skills, personal care skills, cognitive, behavioral and social care, basic restorative services, and patients' rights. Successful course completion shall be determined by passing a competency evaluation test. The minimum number of course hours shall be 75 of which at least 20 hours shall be classroom and at least 40 hours of supervised practice.



experience. The initial orientation to the facility shall be exclusive of the 75 hour training program. Competency evaluation shall be conducted in each of the following areas:

- (1) Observation and documentation;
  - (2) Basic nursing skills;
  - (3) Personal care skills;
  - (4) Mental health and social service needs;
  - (5) Basic restorative services;
  - (6) Residents' Rights.
- (f) Successful course completion and skill competency shall be determined by competency evaluation approved by the Department. Commencing July 1, 1989, nurse aides who had formerly been fully qualified under nurse aide training requirements may re-establish their qualifications by successfully passing a competency evaluation test.

Statutory Authority G.S. 131E-79; 42 U.S.C. 1396 r (b)(5).

## 1919 DENTAL CARE

(a) A dental examination shall be performed at the time of admission with the following information being placed in the patient's or resident's medical or health care record:

- (1) type of diet which the patient or resident can best manage (such as normal, soft or pureed);
- (2) the presence of infection of gums, teeth, or jaws;
- (3) brief descriptions of any removable dental appliances and a statement of their condition; and
- (4) indications for dental treatment at the time of admission.

(b) Names of dentists who have agreed to render emergency dental care shall be maintained at each nursing station and at the supervisor's station in a semi-private home.

(c) Staff of the facility shall ensure that:

- (1) necessary daily dental care is provided;
- (2) each patient or resident possesses appropriate toothbrushes and is encouraged and, when necessary, assisted in their use; and
- (3) each patient or resident having a removable denture is furnished a receptacle in which to immerse the denture in water overnight.

Statutory Authority G.S. 131E-79.

## 1920 AVAILABILITY OF PHARMACEUTICAL SERVICES

(a) A licensed facility shall provide pharmaceutical services under the supervision of a pharmacist currently licensed to practice pharmacy in North Carolina.

(b) A facility shall be responsible for obtaining drugs, therapeutic nutrients and related products prescribed or ordered by a physician for patients or residents in the facility.

(c) Services shall include documented on-site pharmaceutical reviews accomplished at least every 31 calendar days for all patients and residents.

Statutory Authority G.S. 131E-79.

## 1921 DINING FACILITIES

Patients, including wheelchair patients, shall be encouraged to eat at the tables in the dining area and shall be assisted when necessary by non dietary staff. An overbed table shall be provided for patients who eat in bed. A sturdy tray stand shall be provided for those patients who eat out of bed but are unable to go to the dining area. An overbed table which can be lowered to chair height may substitute for the tray stand.

Statutory Authority G.S. 131E-79.

## 1922 ACTIVITIES AND RECREATION

(a) The administrator shall designate an activities and recreation director to be in charge of activities and recreation for all patients and residents. The activities and recreation director shall have training and experience in directing recreational and group activities. The designated activities and recreation director shall be under the supervision of the administrator and shall be qualified to meet the needs of the patients and residents. A qualified individual shall be anyone eligible for a N.C. license as an occupational therapist or assistant therapist under G.S. 90-270; anyone eligible for N.C. certification as a recreation therapist or assistant therapist under G.S. 90C-9; anyone with a baccalaureate degree and one year experience; anyone who has completed an approved 36 hour or longer course in activities program management; or anyone not otherwise qualified but receiving at least four hours consultation per month from one who is qualified.

(b) The facility shall maintain and make available a listing of local resources for activities and recreation to be utilized in meeting the needs and interests of all patients and residents.

(c) Restoration to self care and resumption of normal activity shall be one of the main goals of

the recreation or activity program. The scope of the activity program shall include:

- (1) ~~social activities involving individual and group participation which are designed to promote group relationships;~~
- (2) ~~recreational activities, both indoor and outdoor;~~
- (3) ~~opportunity to participate in activities outside the facility;~~
- (4) ~~religious programs, including the right of each patient and resident to attend the church or religious program of his choice;~~
- (5) ~~creative and expressive activities;~~
- (6) ~~educational activities; and~~
- (7) ~~exercise.~~

(d) ~~The facility shall have written policies and procedures which are available and implemented by staff that:~~

- (1) ~~attempt to prevent the further mental or physical deterioration for those patients or residents who cannot realistically resume normal activities;~~
- (2) ~~assure opportunities for patient involvement, both individual and group, in both planning and implementing the activity program;~~
- (3) ~~provide patients or residents the opportunity for choice among a variety of activities; and~~
- (4) ~~encourage participation by each patient or resident in social and recreational activities according to individual need and abilities and desires unless the patient's or resident's record contains documentation that he is unable to participate.~~

(e) ~~Each patient's or resident's activity plan shall be a part of his overall plan of care and shall contain documentation of periodic assessments of the individual's activity needs and interests. A record of activities and individuals participating shall be maintained in the facility.~~

(f) ~~A licensed facility shall display a monthly activities calendar which includes variety to appeal to different interest groups in the nursing care and domiciliary home services.~~

(g) ~~A licensed facility shall provide:~~

- (1) ~~Space for recreational and diversional activities. In hospitals offering new nursing home services, space shall be provided separately from the main living and dining areas; however, these areas may also be used for social activities.~~
- (2) ~~Designated indoor and outdoor activity~~

~~areas for independent and group need of patients and residents, and which are:~~

- (A) ~~accessible to wheelchair and ambulatory patients; and~~
- (B) ~~of sufficient size to accommodate necessary equipment and permit unobstructed movement of wheelchair and ambulatory patients or personnel responsible for instruction and supervision.~~

(3) ~~Adequate space to store equipment and supplies without blocking exists or otherwise threatening the health and safety of patients and residents.~~

(h) ~~There shall be equipment and supplies sufficient to carry out planned programs for both individual and group activities.~~

Authority G.S. 131E-79; 42 U.S.C. 1396 r (a).

## .1923 SOCIAL SERVICES

(a) ~~The administrator shall designate an employee to be responsible for the provision of social services. This person shall be known as the social services director. Subsequent to the effective date of the rules contained in this Subchapter any newly designated person must be a graduate of a four year college or university with one year's experience in the health care or long term care field or have an equivalent combination of education and experience. An equivalent combination of education and experience means the number of years of education leading to a baccalaureate or associate degree plus the number of years of long term nursing facility experience equal to five years; or eligible for certification as a social worker pursuant to G.S. 90B-7. The social services director shall have authority to carry out provisions contained in Rule .1923(b) of this Section.~~

(b) ~~Each patient's or resident's plan of care shall contain a written plan for meeting his individual social needs and involving his active participation; the plan shall provide for:~~

- (1) ~~needed assistance in meeting the patient's or resident's physical, social and emotional needs through consultation with the patient or resident or his legal guardian, and relative, physician or others;~~
- (2) ~~assisting the patient or resident in adjusting to his environment, for referral to other supporting resources, for protective services, for financial services and for assistance at the time~~



of discharge or transfer into a new environment;

- (3) ~~the utilization of caseworkers employed by the county department of social services in the case of recipients of public assistance and for the utilization of appropriate persons with experience and training in the general area of social work in the case of those not on public assistance.~~

(e) ~~Discharge planning shall be in keeping with each patient's and resident's discharge needs. These are as follows:~~

- (1) ~~The administrator shall assure that a medical order for discharge including any special instructions for meeting rehabilitation potential is obtained from all patients or residents except when a patient or resident leaves against a physician's order or advice; and~~
- (2) ~~The social services director shall coordinate discharge instructions and assure that patients and residents and their families are instructed in accordance with discharge orders.~~

*Statutory Authority G.S. 131E-79.*

## 1924 RESTRAINTS

(a) ~~Patients and residents shall be restrained only by physician orders.~~

(b) ~~The nurse in charge shall be responsible for making the decision relative to necessity for, type and duration of restraint in emergency situations requiring restraints while contacting the physician. The nurse also shall be responsible for documenting same in the patient's or resident's record.~~

(e) ~~The type of restraint used and the time of application and removal shall be recorded by a licensed nurse in the patient's or resident's record.~~

*Statutory Authority G.S. 131E-79.*

## 1925 REQUIRED SPACES

~~The total space requirements shall be those set forth in Rule .1902(4) of this Section. Physical therapy and occupational therapy space shall not be included in these totals.~~

*Statutory Authority G.S. 131E-79.*

## 1926 NURSING HOME PATIENT OR RESIDENT RIGHTS

(a) ~~Written policies and procedures shall be~~

~~developed and enforced to implement requirements in G.S. 131E-115 et seq. (Nursing Home Patients' Bill of Rights) concerning the rights of patients and residents. The administrator shall make these policies and procedures known to the staff, patients and residents, and families of patients and residents and shall ensure their availability to the public by placing them in a conspicuous place.~~

(b) ~~Any violation of patient rights contained in G.S. 131E-117 shall be determined by representatives of the Department by investigation or survey.~~

(e) ~~If a licensed facility is found to be in violation of any of the rights contained in G.S. 131E-117, the Department shall impose penalties for each violation as provided by G.S. 131E-129.~~

(d) ~~When the Department has been notified that corrective action has been taken for each violation, verification of same shall be made by a representative of the Department.~~

(e) ~~The Department shall calculate a total of all fines levied against a facility based on the number of violations and the number of days and patients or residents involved in each violation.~~

(f) ~~The Department shall mail a statement to the facility showing a total fine for each violation and a total of fines due to be paid for all violations. The facility shall pay the penalty within 60 days unless a hearing is requested under G.S. Chapter 150B.~~

(g) ~~When it is found that a violation of G.S. 131E-117 has occurred but corrective action was taken prior to the date of discovery, fines shall be calculated and assessed in accordance with (e) and (f) of this Rule.~~

(h) ~~In matters of patient abuse, neglect or misappropriation the definitions shall have the meanings defined for abuse, neglect and exploitation respectively as contained in the North Carolina PROTECTION OF THE ABUSED, NEGLECTED OR EXPLOITED DISABLED ADULT ACT, G.S. 108A-99 et seq.~~

*Authority G.S. 131E-79; 42 U.S.C. 1396r(e)(2)(B).*

## .1927 BRAIN INJURY LONG-TERM CARE PHYSICIAN SERVICES

(a) ~~For nursing facility patients located in designated brain injury long term care units, there shall be an attending physician who is responsible for the patient's specialized care program. The intensity of the program requires that there shall be direct patient contact by a physician at least once per week and more often as the patient's condition~~

warrants. Each patient's interdisciplinary, long term care program shall be developed and implemented under the supervision of a physiatrist (a physician trained in Physical Medicine and Rehabilitation) or a physician of equivalent training and experience.

(b) If a physiatrist or physician of equivalent training or experience, is not available on a weekly basis to the facility, the facility shall provide for weekly medical management of the patient, by another physician. In addition, oversight for the patient's interdisciplinary, long term care program shall be provided by a qualified consultant physician who visits patients monthly, makes recommendations for and approves the interdisciplinary care plan, and provides consultation as requested to the physician who is managing the patient on a weekly basis.

(c) The attending physician shall actively participate in individual case conferences or care planning sessions and shall review and sign discharge summaries and records within 15 days of patient discharge. When patients are to be discharged to either another health care facility or a residential setting the attending physician shall assure that the patient has been provided with a discharge plan which incorporates optimum utilization of community resources and post discharge continuity of care and services.

Statutory Authority G.S. 131E-79.

## .1928 BRAIN INJURY LONG-TERM CARE PROGRAM REQUIREMENTS

(a) The general requirements in this Subchapter shall apply when applicable, but brain injury long term care units shall meet the supplement requirements in this Rule and Rules .1901 (4) and .1929 of this Section. Brain injury long term care is an interdisciplinary, intensive maintenance program for patients who have incurred brain damage caused by external physical trauma and who have completed a primary course of rehabilitative treatment and have reached a point of no gain or progress for more than three consecutive months. Services are provided through a medically supervised interdisciplinary process as provided in Rule .1927 of this Section and are directed toward maintaining the individual at the optimal level of physical, cognitive and behavioral functioning. Following are the minimum requirements for specific services that may be necessary to maintaining the individual at optimum level:

(1) Overall supervisory responsibility for

brain injury long term care service shall be assigned to a registered nurse with one year experience in caring for brain injured patients.

(2) Physical therapy shall be provided by physical therapist with a current valid North Carolina license. Occupational therapy shall be provided by an occupational therapist with a current valid North Carolina License. The services of a physical therapist and occupational therapist shall be combined to provide one full time equivalent for each 20 patients. The assistance of a physical therapy aide and an occupational therapy aide with appropriate supervision shall be combined to provide one full time equivalent for each 20 patients. A proportionate number of hours shall be provided for a census less than 20 patients.

(3) Clinical nutrition services shall be provided by a qualified dietician with two years clinical training and experience in nutrition. The number of hours of clinical nutrition services on either a full time or part time employment or contract basis shall be adequate to meet the needs of the patients. Each patient's nutrition need shall be reviewed at least monthly. Clinical nutrition services shall include

(A) Assessing the appropriateness of the ordered diet for conformance with each patient's physiological and pharmacological condition;

(B) Evaluating each patient's laboratory data in relation to nutritional status and hydration;

(C) Applying technical knowledge of feeding tubes, pumps and equipment to each patient's specialized needs.

(4) Clinical Social Work shall be provided by a Social Worker meeting the requirements of Rule .1923 of this Section.

(5) Recreation therapy, when required shall be provided on either a full time or part time employment or contract basis by a clinician eligible for certification as a therapeutic recreation specialist by the State Board of Therapeutic Recreation Certification. The number of hours of therapeutic



recreation services shall be adequate to meet the needs of the patients. In the event that a qualified specialist is not locally available, alternate treatment modalities shall be developed by the occupational therapist and reviewed by the attending physician. The program designed must be adequate to meet the needs of this specialized population and must be administered in accordance with Section .1200 of this Subchapter.

(6) Speech therapy, when required, shall be provided by a clinician with a current valid license in speech pathology issued by the State Board of Audiology and Speech Pathology.

(7) Respiratory therapy, when required, shall be provided and supervised by a respiratory therapist currently registered by the National Board for Respiratory Care.

(b) Each patient's program shall be governed by interdisciplinary treatment plan incorporating and expanding upon the health plan required under Rules .1908 and .1909 of this Section. The plan is to be initiated on the first day of admission. Upon completion of baseline data development and integrated interdisciplinary assessment the initial treatment plan is to be expanded and finalized within 14 days of admission. Through an interdisciplinary process the treatment plan shall be reviewed at least monthly and revised as appropriate. In executing the treatment plan the interdisciplinary team shall be the major decision making body and shall determine the goals, process, and the frames for accomplishment of each patient's program. Disciplines to be represented on the team shall be medicine, nursing, clinical pharmacy and all other disciplines directly involved in the patient's treatment or treatment plan.

(c) Each patient's overall program shall be assigned to an individually designated case manager. The case manager acts as the coordinator and manager for assigned patients. Any professional staff member involved in the patient's care may be assigned this responsibility for one or more patients. Professional staff may divide this responsibility for all patients on the unit in the best manner to meet all patients' needs for a coordinated interdisciplinary approach to care. The case manager shall be responsible for:

- (1) coordinating the development, implementation and periodic review of the patient's treatment plan;
- (2) preparing a monthly summary of the

patient's progress;

- (3) cultivating the patient's participation in the program;
- (4) general supervision of the patient during the course of treatment;
- (5) evaluating appropriateness of the treatment plan in relation to the attainment of stated goals; and
- (6) assuring that discharge decisions and arrangements for post discharge follow up are properly made.

(d) For each 20 patients or fraction thereof dedicated treatment facilities and equipment shall be provided as follows:

- (1) A combined therapy space equal to or exceeding 600 square feet, adequately equipped and arranged to support each of the therapies.
- (2) Access to one full reclining wheelchair per patient.
- (3) Special physical therapy and occupational therapy equipment for use in fabricating positioning devices for beds and wheelchairs including splints, casts, cushions, wedges, and bolsters.
- (4) There shall be roll in bath facilities with a dressing area available to all patients which shall afford maximum privacy to the patient.

Statutory Authority G.S. 131E-79.

## .1929 SPECIAL NURSING REQUIREMENTS FOR BRAIN INJURY LONG-TERM CARE

Direct care nursing personnel staffing ratio (NH/PD) established in Rule .1912 of this Section shall not be applied to nursing services for patients who require brain injury long term care, due to their more intensive maintenance and nursing needs. The minimum direct care nursing staff shall be 5.5 hrs. per patient day allocated on a per shift basis as the facility chooses to appropriately meet the patient's needs. It is also required that regardless of how low the patient census the direct care nursing staff shall not fall below a registered nurse and a nurse aide I at any time during a 24 hour period.

Statutory Authority G.S. 131E-79.

## .1930 VENTILATOR DEPENDENCE

The general requirements in this Subchapter shall apply when applicable. In addition, facilities having patients requiring the use of ventilators for

more than eight hours a day must meet the following requirements:

- (1) ~~Respiratory therapy shall be provided and supervised by a respiratory therapist currently registered by the National Board for Respiratory Care. The respiratory therapist shall:~~
  - (a) ~~make, as a minimum, weekly on-site assessments of each patient receiving ventilator support with corresponding progress notes;~~
  - (b) ~~be on call 24 hours daily; and~~
  - (c) ~~assist the pulmonologist and nursing staff in establishing ventilator policies and procedures, including emergency policies and procedures.~~
- (2) ~~Direct nursing care staffing shall be in accordance with Rule .1912 of this Section.~~

*Statutory Authority G.S. 131E-79.*

### **.1931 PHYSICIAN SERVICES FOR VENTILATOR DEPENDENT PATIENTS**

~~Hospitals with nursing facility beds with ventilator dependent care patients shall contract with a physician who is licensed to practice in North Carolina with Board Certification and who has specialized training in pulmonary medicine. This physician shall be responsible for respiratory services and shall:~~

- (1) ~~establish, with the respiratory therapist and nursing staff, appropriate ventilator policies and procedures, including emergency procedures;~~
- (2) ~~assess each ventilator patient's status at least monthly with corresponding progress notes;~~
- (3) ~~be available on an emergency basis; and~~
- (4) ~~participate in individual patient case planning.~~

*Statutory Authority G.S. 131E-79.*

### **.1932 EMERGENCY ELECTRICAL SERVICE**

~~(a) A minimum of one dedicated emergency branch circuit per bed is required for ventilator dependent patients in addition to the normal system receptacle at each bed location required by the National Electrical Code. This emergency circuit shall be provided with a minimum of two duplex receptacles identified for emergency use. Additional emergency branch circuits/receptacles~~

~~shall be provided where the electrical life support needs of the patient exceed the minimum requirements stated in this Paragraph. Each emergency circuit serving ventilator dependent patients shall be fed from the automatically transferred critical branch of the essential electrical system. This Paragraph shall apply to both new and existing facilities.~~

~~(b) Heating equipment provided for ventilator dependent patient bedrooms shall be connected to the critical branch of the essential electrical system and arranged for delayed automatic or manual connection to the emergency power source if the heating equipment depends upon electricity for proper operation. This Paragraph shall apply to both new and existing facilities.~~

~~(c) Task lighting connected to the automatically transferred critical branch of the essential electrical system shall be provided for each ventilator dependent patient bedroom. This Paragraph shall apply to both new and existing facilities.~~

*Statutory Authority G.S. 131E-79.*

## **SECTION .2000 - SPECIALLY DESIGNATED UNITS**

### **.2001 ADMISSIONS TO THE HIV DESIGNATED UNIT**

~~If a facility declines admission to a patient known to have Human Immunodeficiency Virus disease the reasons for the denial shall be documented.~~

*Statutory Authority G.S. 131E-79.*

### **.2002 DISCHARGE OF PATIENTS FROM THE HIV DESIGNATED UNIT**

~~A record shall be maintained of all discharges of patients indicating the reasons for discharge, the physician's order for or other authorization for discharge, and the condition of the patient at the time of discharge.~~

~~A patient known to have Human Immunodeficiency Virus disease may not be discharged solely on the basis of the diagnosis of Human Immunodeficiency Virus disease except as authorized by the provisions of N.C. General Statute 131E-117 (15) or other provisions of the N.C. General Statutes or regulations promulgated thereunder or provision of applicable federal laws and regulations.~~

*Statutory Authority G.S. 131E-79.*

### **.2003 HIV DESIGNATED UNIT POLICIES AND PROCEDURES**



(a) In units dedicated to the treatment of patients with Human Immunodeficiency Virus disease, policies and procedures specific to the specialized needs of the patients served shall be developed. At a minimum they shall include staff training and education, and the availability of consultation by a physician with specialized education or knowledge in the management of Human Immunodeficiency Virus disease.

(b) Policies and procedures for infection control shall be in conformance with 29 CFR 1910 Occupational Safety and Health Standards which is incorporated by reference including subsequent amendments. Emphasis shall be placed on compliance with 29 CFR 1910.1030 (Bloodborne pathogens). Copies of Title 29 Part 1910 may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 for \$38.00 and may be purchased with a credit card by a direct telephone call to the G.P.O. at (202) 783-3238. Infection control shall also be in compliance with the Center of Disease Control Guidelines as published by the U.S. Department of Health and Human Services, Public Health Service which is incorporated by reference including subsequent amendments. Copies may be purchased from the National Technical Information Service, U.S. Department of Commerce, 5285 Port Royal Road, Springfield, Virginia, 22161 for \$5.95.

Statutory Authority G.S. 131E-79.

#### 2004 PHYSICIAN SERVICES IN A HIV DESIGNATED UNIT

In facilities with a Human Immunodeficiency Virus designated unit the facility shall insure that attending physicians have documented, pre-arranged access, either in person or by telephone, to a physician with specialized education or knowledge in the management of Human Immunodeficiency Virus Disease.

Statutory Authority G.S. 131E-79.

#### 2005 SPECIAL NURSING REQUIREMENTS FOR A HIV DESIGNATED UNIT

(a) Facilities with a Human Immunodeficiency Virus designated unit shall have a registered nurse with specialized education or knowledge in the care of Human Immunodeficiency Virus disease.

(b) Nursing personnel assigned to the Human Immunodeficiency Virus unit shall be regularly assigned to the unit. Rotations are acceptable to alleviate staff burnout or staffing emergencies.

Statutory Authority G.S. 131E-79.

#### 2006 SPECIALIZED STAFF EDUCATION FOR THE HIV DESIGNATED UNIT

For facilities with a Human Immunodeficiency Virus designated unit an organized, documented program of education specific to the care of patients infected with the Human Immunodeficiency Virus shall be provided and include at a minimum:

- (1) Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome disease processes;
- (2) transmission modes, causes, and prevention of Human Immunodeficiency Virus;
- (3) treatment of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome;
- (4) psycho-socio-economic needs of the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome patients;
- (5) in addition to the general hospital orientation to Occupational Safety and Health Administration guidelines for universal precautions, orientation to infection control specific to Human Immunodeficiency Virus disease must be provided upon employment or permanent assignment to the unit; Copies of Title 29 Part 1910 may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 for \$38.00 and may be purchased with a credit card by a direct telephone call to the G.P.O. at (202) 783-3238;
- (6) policies and procedures specific to the Human Immunodeficiency Virus designated unit; and
- (7) annual continuing education in infection control.

Statutory Authority G.S. 131E-79.

#### 2007 USE OF INVESTIGATIONAL DRUGS ON THE HIV DESIGNATED UNIT

(a) The supervision and monitoring for the administration of investigational drugs is the responsibility of the pharmacist and a licensed registered nurse, acting pursuant to the orders of a physician duly authorized to prescribe or dispense such drugs. Responsibilities shall include, but not be limited to, the following:

- (1) ~~to insure the provision of written guidelines for any investigational drug or study are provided; and~~
- (2) ~~training and determination of staff's abilities regarding administration of drugs, policies and procedures and regulations.~~

(b) The pharmacist or physician dispensing the investigational drug is to provide the facility with information regarding at least the following:

- (1) ~~a copy of the protocol, including drug information;~~
- (2) ~~a copy of the patient's informed consent;~~
- (3) ~~drug storage;~~
- (4) ~~handling;~~
- (5) ~~any specific preparation and administration instructions;~~
- (6) ~~specific details for drug accountability, resupply and return of unused drug; and~~
- (7) ~~a copy of the signed consent to participate in the study.~~

(e) Labeling of investigational drugs shall be in accordance with written guidelines of protocol and State and federal requirements regarding such drugs. Prescription labels for investigational drugs are to be distinguishable from other labels by an appropriate legend, "Investigational Drug" or "For Investigational Use Only".

Statutory Authority G.S. 131E-79.

## .2008 SOCIAL WORK SERVICES IN A HIV DESIGNATED UNIT

The facility shall provide either by direct employment or by contract for social work services to include assistance to the patient in identification of supportive resources, financial services and assistance with discharge and transfer arrangements. In addition, for patients in a Human Immunodeficiency Virus disease designated unit, the social worker shall provide or arrange for the provision of spiritual, pastoral and grief counseling for patients and staff where appropriate. Support services shall be provided to patient families and significant others. Where necessary, coordination with treatment services for substance abuse, legal services and other community resources shall be identified.

Statutory Authority G.S. 131E-79.

## RULES .2009 - .2019 RESERVED FOR FUTURE CODIFICATION

## .2020 DEFINITIONS

The following definitions shall apply to inpatient rehabilitation facilities or units only:

- (1) ~~"Case management" means the coordination of services, for a given patient, between disciplines so that the patient may reach optimal rehabilitation through the judicious use of resources.~~
- (2) ~~"Comprehensive, inpatient rehabilitation program" means a program for the treatment of persons with functional limitations or chronic disabling conditions who have the potential to achieve significant improvement in activities of daily living. A comprehensive rehabilitation program utilizes coordinated and integrated interdisciplinary approach, directed by a physician, to assess patient needs and provide treatment and evaluation of physical, psycho-social and cognitive deficits.~~
- (3) ~~"Inpatient rehabilitation facility or unit" means a free standing facility or a unit (unit pertains to contiguous dedicated beds and spaces) within an existing licensed health service facility approved in accordance with G.S. 131E, Article 1 to establish inpatient, rehabilitation beds and to provide a comprehensive, inpatient rehabilitation program.~~
- (4) ~~"Medical consultations" mean consultations which the rehabilitation physician or the attending physician determine are necessary to meet the acute medical needs of the patient and do not include routine medical needs.~~
- (5) ~~"Occupational therapist" means an individual licensed in the State of North Carolina as an occupational therapist in accordance with the provisions of G.S. 90, Article 18D.~~
- (6) ~~"Occupational therapist assistant" means any individual licensed in the State of North Carolina as an occupational therapist assistant in accordance with the provisions of G.S. 90, Article 18D.~~
- (7) ~~"Psychologist" means a person licensed as a practicing psychologist in accordance with G.S. 90, Article 18A.~~
- (8) ~~"Physiatrist" means a licensed physician who has completed a physical medicine and rehabilitation residency training program approved by the Accrediting~~



- Council of Graduate Medical Education or the American Osteopathic Association.
- (9) ~~"Physical therapist" means any person licensed in the State of North Carolina as a physical therapist in accordance with the provisions of G.S. 90, Article 18B.~~
- (10) ~~"Physical therapist assistant" means any person duly licensed in the State of North Carolina as a physical therapist assistant in accordance with the provisions of G.S. 90-270.24, Article 18B.~~
- (11) ~~"Recreational therapist" means a person certified by the State of North Carolina Therapeutic Recreational Certification Board.~~
- (12) ~~"Rehabilitation nurse" means a registered nurse licensed in North Carolina, with training, either academic or on the job, in physical rehabilitation nursing and at least one year experience in physical rehabilitation nursing.~~
- (13) ~~"Rehabilitation aide" means an unlicensed assistant who works under the supervision of a registered nurse, licensed physical therapist or occupational therapist in accordance with the appropriate occupational licensure laws governing his or her supervisor and consistent with staffing requirements as set forth in Rule 2027 of this Section. The rehabilitation aide shall be listed on the North Carolina Nurse Aide Registry and have received additional staff training as listed in Rule 2028 of this Section.~~
- (14) ~~"Rehabilitation physician" means a psychiatrist or a physician who is qualified, based on education, training and experience regardless of specialty, of providing medical care to rehabilitation patients.~~
- (15) ~~"Social worker" means a person certified by the North Carolina Certification Board for Social Work in accordance with G.S. 90B-3.~~
- (16) ~~"Speech and language pathologist" means any person licensed in the State of North Carolina as a speech and language pathologist in accordance with the provisions of G.S. 90, Article 22.~~

(a) ~~In a rehabilitation facility or unit a physician shall participate in the provision and management of rehabilitation services and in the provision of medical services.~~

(b) ~~In a rehabilitation facility or unit a rehabilitation physician shall be responsible for a patient's interdisciplinary treatment plan. Each patient's interdisciplinary treatment plan shall be developed and implemented under the supervision of a rehabilitation physician.~~

(c) ~~The rehabilitation physician shall participate in the preliminary assessment within 48 hours of admission, prepare a plan of care and direct the necessary frequency of contact based on the medical and rehabilitation needs of the patient. The frequency shall be appropriate to justify the need for comprehensive inpatient rehabilitation care.~~

(d) ~~An inpatient rehabilitation facility or unit's contract or agreements with a rehabilitation physician shall require that the rehabilitation physician shall participate in individual case conferences or care planning sessions and shall review and sign discharge summaries and records. When patients are to be discharged to another health care facility, the discharging facility shall assure that the patient has been provided with a discharge plan which incorporates post discharge continuity of care and services. When patients are to be discharged to a residential setting, the facility shall assure that the patient has been provided with a discharge plan that incorporates the utilization of community resources when available and when included in the patient's plan of care.~~

(e) ~~The intensity of physician medical services and the frequency of regular contacts for medical care for the patient shall be determined by the patient's pathophysiologic needs.~~

(f) ~~Where the attending physician of a patient in an inpatient rehabilitation facility or unit orders medical consultations for the patient, such consultations shall be provided by qualified physicians within 48 hours of the physician's order. In order to achieve this result, the contracts or agreements between inpatient rehabilitation facilities or units and medical consultants shall require that such consultants render the requested medical consultation within 48 hours.~~

(g) ~~An inpatient rehabilitation facility or unit shall have a written procedure for setting the qualifications of the physicians rendering physical rehabilitation services in the facility or unit.~~

Statutory Authority G.S. 131E-79; 143B-165.

## 2021 PHYSICIAN REQS FOR INPATIENT REHABILITATION FACILITIES OR UNITS

Statutory Authority G.S. 131E-79; 143B-165.

## **.2022 ADMISSION CRITERIA FOR INPATIENT REHABILITATION FACILITIES OR UNITS**

(a) ~~The facility shall have written criteria for admission to the inpatient rehabilitation facility or unit. A description of programs or services for screening the suitability of a given patient for placement shall be available to staff and referral sources.~~

(b) ~~For patients found unsuitable for admission to the inpatient rehabilitation facility or unit, there shall be documentation of the reasons.~~

(c) ~~Within 48 hours of admission a preliminary assessment shall be completed by members of the interdisciplinary team to insure the appropriateness of placement and to identify the immediate needs of the patient.~~

(d) ~~Patients admitted to an inpatient rehabilitation facility or unit must be able to tolerate a minimum of three hours of rehabilitation therapy, five days a week, including at least two of the following rehabilitation services: physical therapy, occupational therapy or speech therapy.~~

(e) ~~Patients admitted to an inpatient rehabilitation facility or unit must be medically stable, have a prognosis indicating a progressively improved medical condition and have the potential for increased independence.~~

*Statutory Authority G.S. 131E-79; 143B-165.*

## **.2023 COMPREHENSIVE INPATIENT REHABILITATION EVALUATION**

(a) ~~A comprehensive, inpatient rehabilitation evaluation is required for each patient admitted to an inpatient rehabilitation facility or unit. At a minimum this evaluation shall include the reason for referral, a summary of the patient's clinical condition, functional strengths and limitations, and indications for specific services. This evaluation shall be completed within three days.~~

(b) ~~Each patient shall be evaluated by the interdisciplinary team to determine the need for any of the following services: medical, dietary, occupational therapy, physical therapy, prosthetics and orthotics, psychological assessment and therapy, therapeutic recreation, rehabilitation medicine, rehabilitation nursing, therapeutic counseling or social work, vocational rehabilitation evaluation and speech language pathology.~~

*Statutory Authority G.S. 131E-79; 143B-165.*

## **.2024 COMPREHENSIVE INPATIENT REHABILITATION INTER-**

## **DISCIPLINARY TREAT/PLAN**

(a) ~~The interdisciplinary treatment team shall develop an individual treatment plan for each patient within seven days after admission. The plan shall include evaluation findings and information about the following:~~

- ~~(1) prior level of function;~~
- ~~(2) current functional limitations;~~
- ~~(3) specific service needs;~~
- ~~(4) treatment, supports and adaptations to be provided;~~
- ~~(5) specified treatment goals;~~
- ~~(6) disciplines responsible for implementation of separate parts of the plan; and~~
- ~~(7) anticipated time frames for the accomplishment of specified long term and short term goals.~~

(b) ~~The treatment plan shall be reviewed by the interdisciplinary team at least every other week. All members of the interdisciplinary team, or representative of their discipline, shall attend each meeting. Documentation of each review shall include progress toward defined goals and identification of any changes in the treatment plan.~~

(c) ~~The treatment plan shall include provisions for all of the services identified as needed for the patient in the comprehensive, inpatient rehabilitation evaluation completed in accordance with Rule .2023 of this Subchapter.~~

(d) ~~Each patient shall have a designated case manager who is responsible for the coordination of the patient's individualized treatment plan. The case manager is responsible for promoting the program's responsiveness to the needs of the patient and shall participate in all team conferences concerning the patient's progress toward the accomplishment of specified goals. Any of the professional staff involved in the patient's care may be the designated case manager for one or more cases, or the director of nursing or social worker may accept the coordination responsibility for the patients.~~

*Statutory Authority G.S. 131E-79; 143B-165.*

## **.2025 DISCHARGE CRITERIA FOR INPATIENT REHABILITATION FACILITIES OR UNITS**

(a) ~~Discharge planning shall be an integral part of the patient's treatment plan and shall begin upon admission to the facility. After established goals have been reached, or a determination has been made that care in a less intensive setting would be appropriate, or that further progress is unlikely~~



a patient shall be discharged to an appropriate setting. Other reasons for discharge may include inability or unwillingness of patient or family to operate with the planned therapeutic program or medical complications that preclude a further intensive rehabilitative effort. The facility shall involve the patient, family, staff members and referral sources in discharge planning.

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

(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 recommendations and activities and procedures used by the patient to maintain and improve functioning.

Statutory Authority G.S. 131E-79; 143B-165.

## 026 COMPREHENSIVE REHABILITATION PERSONNEL ADMINISTRATION

(a) The facility shall have qualified staff members, consultants and contract personnel to provide services to the patients admitted to the patient rehabilitation facility or unit.

(b) Personnel shall be employed or provided by contractual agreement in sufficient types and numbers to meet the needs of all patients admitted for comprehensive rehabilitation.

(c) Written agreements shall be maintained by the facility when services are provided by contract on an ongoing basis.

Statutory Authority G.S. 131E-79; 143B-165.

## 027 COMPREHENSIVE INPATIENT REHABILITATION PROGRAM STAFFING REQ

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

(1) The inpatient rehabilitation facility or unit shall be supervised by a rehabilitation nurse. The facility shall identify the nursing skills necessary to meet the needs of the rehabilitation patients in the unit and assign staff qualified to meet those needs.

(2) The minimum nursing hours per patient

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

(3) The inpatient rehabilitation unit shall employ or provide by contractual agreements sufficient therapists, licensed in North Carolina, 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 licensed or certified and shall be supervised on site by licensed physical therapists or licensed occupational therapists.

(5) Rehabilitation aides shall have documented training appropriate to the activities to be performed and the occupational licensure laws of his or her supervisor. The overall responsibility for the on going supervision and evaluation of the rehabilitation aide remains with the registered nurse as identified in Subparagraph (a)(1) of this Rule. Supervision by the licensed 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.

(6) Hours of service by the rehabilitation aide are counted toward the required nursing hours when the aide is working under the supervision of the licensed 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 licensed 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 requirements 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.

Statutory Authority G.S. 131E-79; 143B-165.

**.2028 STAFF TRAINING FOR INPATIENT REHABILITATION FACILITIES OR UNIT**

Prior to the provision of care, all rehabilitation personnel, excluding physicians, assigned to the rehabilitation unit shall be provided training or shall provide documentation of training, that includes at a minimum the following:

- (1) active and passive range of motion;
- (2) assistance with ambulation;
- (3) transfers;
- (4) maximizing functional independence;
- (5) the psycho social needs of the rehabilitation patient;
- (6) the increased safety risks of rehabilitation training (including falls and the use of restraints);
- (7) proper body mechanics;
- (8) nutrition, including dysphagia and restorative eating;
- (9) communication with the aphasic and hearing impaired patient;
- (10) behavior modification;
- (11) bowel and bladder training; and
- (12) skin care.

Statutory Authority G.S. 131E-79; 143B-165.

**.2029 EQUIPMENT REQS/ COMPREHENSIVE INPATIENT REHABILITATION PROGRAMS**

(a) The facility shall provide each discipline with the necessary equipment and treatment methods to achieve the short and long term goals specified in the comprehensive inpatient rehabilitation interdisciplinary treatment plans for patients admitted to these facilities or units.

(b) Each patient's needs for a standard wheelchair or a specially designed wheelchair or additional devices to allow safe and independent mobility within the facility shall be met.

(c) Special physical therapy and occupational therapy equipment for use in fabricating positioning devices for beds and wheelchairs shall be provided, including splints, casts, cushions, wedges and bolsters.

(d) Physical therapy devices, including a mat table, parallel bars and sliding boards and special adaptive bathroom equipment shall be provided.

Statutory Authority G.S. 131E-79; 143B-165.

**.2030 PHYSICAL FACILITY REQS/ INPATIENT REHABILITATION FACILITIES OR UNITS**

(a) The inpatient rehabilitation facility or unit shall be in a designated area and shall be used for the specific purpose of providing a comprehensive inpatient rehabilitation program.

(b) The floor area of a single bedroom shall be sufficient for the patient or the staff to easily transfer the patient from the bed to a wheelchair and to maneuver a 180 degree turn with wheelchair on at least one side of the bed.

(c) The floor area of a multi-bed bedroom shall be sufficient for the patient or the staff to easily transfer the patient from the bed to a wheelchair and to maneuver a 180 degree turn with wheelchair between beds.

(d) Each patient room shall meet the following requirements:

- (1) Maximum room capacity of no more than four patients;
- (2) Operable windows;
- (3) A nurse call system designed to meet the special needs of rehabilitative patients;
- (4) In single and two bed rooms with private toilet room, the lavatory may be located in the toilet room;
- (5) A wardrobe or closet for each patient which is wheelchair accessible and arranged to allow the patient to access the contents;
- (6) A chest of drawers or built in drawer storage with mirror above, which is wheelchair accessible; and
- (7) A bedside table for toilet articles and personal belongings.

(e) Space for emergency equipment such as resuscitation carts shall be provided and shall be under direct control of the nursing staff, in proximity to the nurse's station and out of traffic.

(f) Patients' bathing facilities shall meet the following specifications:

- (1) There shall be at least one shower stall or one bathtub for each 15 beds not individually served. Each tub or shower shall be in an individual room or privacy enclosure which provides space for the private use of the bathing fixture, for drying and dressing and for a wheelchair and an assisting attendant.
- (2) Showers in central bathing facilities shall be at least five foot square without curbs and designed to permit use by a wheelchair patient.



(3) ~~At least one five foot by seven foot shower shall be provided which can accommodate a stretcher and an assisting attendant.~~

(g) ~~Patients' toilet rooms and lavatories shall set the following specifications:~~

(1) ~~The size of toilets shall permit a wheelchair, a staff person and appropriate wheel to water closet transfers.~~

(2) ~~A lavatory in the room must permit wheelchair access.~~

(3) ~~Lavatories serving patients shall:~~

(A) ~~allow wheelchairs to extend under the lavatory; and~~

(B) ~~have water supply spout mounted so that its discharge point is a minimum of five inches above the rim of the fixture.~~

(4) ~~Lavatories used by patients and by staff shall be equipped with blade operated supply valves.~~

(h) ~~The space provided for physical therapy, occupational therapy and speech therapy by all patient rehabilitation facilities or units may be varied but must, at a minimum, include:~~

(1) ~~office space for staff;~~

(2) ~~office space for speech therapy evaluation and treatment;~~

(3) ~~waiting space;~~

(4) ~~training bathroom which includes toilet, lavatory and bathtub;~~

(5) ~~gymnasium or exercise area;~~

(6) ~~work area such as tables or counters suitable for wheelchair access;~~

(7) ~~treatment areas with available privacy curtains or screens;~~

(8) ~~an activities of daily living training kitchen with sink, cooking top (secured when not supervised by staff), refrigerator and counter surface for meal preparation;~~

(9) ~~storage for clean linens, supplies and equipment;~~

(10) ~~janitor's closet accessible to the therapy area with floor receptor or service sink and storage space for housekeeping supplies and equipment, one closet or space may serve more than one area of the inpatient rehabilitation facility or unit; and~~

(11) ~~hand washing facilities.~~

(i) ~~For social work and psychological services the following shall be provided:~~

(1) ~~office space for staff;~~

(2) ~~office space for private interviewing and counseling for all family members; and~~

(3) ~~workspace for testing, evaluation and counseling.~~

(j) ~~If prosthetics and orthotics services are provided, the following space shall be made available as necessary:~~

(1) ~~work space for technician; and~~

(2) ~~space for evaluation and fittings (with provisions for privacy).~~

(k) ~~If vocational therapy services are provided, the following space shall be made available as necessary:~~

(1) ~~office space for staff;~~

(2) ~~workspace for vocational services activities such as prevocational and vocational evaluation;~~

(3) ~~training space;~~

(4) ~~storage for equipment; and~~

(5) ~~counseling and placement space.~~

(l) ~~Recreational therapy space requirements include the following:~~

(1) ~~activities space;~~

(2) ~~storage for equipment and supplies;~~

(3) ~~office space for staff; and~~

(4) ~~access to male and female toilets.~~

(m) ~~The following space shall be provided for patient's dining, recreation and day areas:~~

(1) ~~sufficient room for wheelchair movement and wheelchair dining seating;~~

(2) ~~if food service is cafeteria type, adequate width for wheelchair maneuvers, queue space within the dining area (and not in a corridor) and a serving counter low enough to view food;~~

(3) ~~total space for inpatients, a minimum of 25 square feet per bed;~~

(4) ~~for outpatients participating in a day program or partial day program, 20 square feet when dining is a part of the program and 10 square feet when dining is not a part of the program; and~~

(5) ~~storage for recreational equipment and supplies, tables and chairs.~~

(n) ~~The patient dining, recreation and day area spaces shall be provided with windows that have glazing of an area not less than eight percent of the floor area of the space. At least one half of the required window area must be operable.~~

(o) ~~A laundry shall be available and accessible for patients.~~

Statutory Authority G.S. 131E-79; 143B-165.

### .2031 ADDITIONAL REQUIREMENTS FOR TRAUMATIC BRAIN INJURY PATIENTS

Inpatient rehabilitation facilities providing services to persons with traumatic brain injuries shall meet the requirements in this Rule in addition to those identified in this Section.

- (1) Direct care nursing personnel staffing ratios established in Rule .2027 of this Section shall not be applied to nursing services for traumatic brain injury patients in the inpatient, rehabilitation facility or unit. The minimum nursing hours per traumatic brain injury patient in the unit shall be 6.5 nursing hours per patient day. At no time shall direct care nursing staff be less than two full time equivalents, one of which shall be a registered nurse.
- (2) The inpatient rehabilitation facility or unit shall employ or provide by contractual agreements physical, occupational or speech therapists in order to provide a minimum of 4.5 hours of specific or combined rehabilitation therapy services per traumatic brain injury patient day.
- (3) The facility shall provide special facility or equipment needs for patients with traumatic brain injury, including a quiet room for therapy, specially designed wheelchairs and standing tables.
- (4) The medical director of an inpatient traumatic brain injury program shall have two years management in a brain injury program, one of which may be in a clinical fellowship program and board eligibility or certification in the medical specialty of the physician's training.
- (5) The facility shall provide the consulting services of a neuropsychologist.
- (6) The facility shall provide continuing education in the care and treatment of brain injury patients for all staff.
- (7) The size of the brain injury program shall be adequate to support a comprehensive, dedicated ongoing brain injury program.

Statutory Authority G.S. 131E-79; 143B-165.

### .2032 ADDITIONAL REQUIREMENTS FOR SPINAL CORD INJURY PATIENTS

Inpatient rehabilitation facilities providing services to persons with spinal cord injuries shall meet

the requirements in this Rule in addition to the identified in this Section.

- (1) Direct care nursing personnel staffing ratios established in Rule .2027 of this Section shall not be applied to nursing services for spinal cord injury patients in the inpatient, rehabilitation facility or unit. The minimum nursing hours per spinal cord injury patient in the unit shall be 6.0 nursing hours per patient day. At no time shall direct care nursing staff be less than two full time equivalents, one of which shall be a registered nurse.
- (2) The inpatient rehabilitation facility or unit shall employ or provide by contractual agreements physical, occupational or speech therapists in order to provide a minimum of 4.0 hours of specific or combined rehabilitation therapy services per spinal cord injury patient day.
- (3) The facility shall provide special facility or special equipment needs of patients with spinal cord injury, including specially designed wheelchairs, tilt tables and standing tables.
- (4) The medical director of an inpatient spinal cord injury program shall have either two years experience in the medical care of persons with spinal cord injuries or six month's minimum in spinal cord injury fellowship.
- (5) The facility shall provide continuing education in the care and treatment of spinal cord injury patients for all staff.
- (6) The facility shall provide specific staff training and education in the care and treatment of spinal cord injury.
- (7) The size of the spinal cord injury program shall be adequate to support a comprehensive, dedicated ongoing spinal cord injury program.

Statutory Authority G.S. 131E-79; 143B-165.

### .2033 DEEMED STATUS FOR INPATIENT REHABILITATION FACILITIES OR UNITS

(a) If an inpatient rehabilitation facility or unit with a comprehensive inpatient rehabilitation program is surveyed and accredited by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF) and has been approved by the Department in accordance with Article 9 Chapter 131E of the



North Carolina General Statutes, the Department deems the facility to be in compliance with Rules 2020 through 2030 and 2033 of this Section:

(b) Deemed status shall be provided only if the inpatient rehabilitation facility or unit provides copies of survey reports to the Division. The CAHO report shall show that the facility or unit was surveyed for rehabilitation services. The SARF report shall show that the facility or unit was surveyed for comprehensive rehabilitation services. The facility or unit shall sign an agreement (Memorandum of Understanding) specifying these terms.

(c) The inpatient rehabilitation facility or unit shall be subject to inspections or complaint investigations by representatives of the Department at any time. If the facility or unit is found not to be in compliance with the rules listed in Paragraph (a) of this Rule, the facility shall submit a plan of correction and be subject to a follow up visit to assure compliance.

(d) If the inpatient rehabilitation facility or unit ceases or does not renew its accreditation, the facility or unit shall notify the Division in writing within 30 days.

Statutory Authority G.S. 131E-79.

## SECTION .2100 - SUPPLEMENTAL RULES FOR THE LICENSURE OF DESIGNATED PRIMARY CARE HOSPITALS AND FEDERALLY CERTIFIED PRIMARY CARE HOSPITALS

### .2101 SUPPLEMENTAL RULES

The rules of this Section pertain only to designated Primary Care Hospitals or Federally Certified Primary Care Hospitals. The general requirements of this Subchapter shall apply to such hospitals except where they are specifically waived or modified by the rules of this Section.

Statutory Authority G.S. 131E-76; 131E-79.

### .2102 DEFINITIONS

The following definitions shall apply throughout this Section, unless text otherwise clearly indicates to the contrary:

- (1) "Available" means provided directly by the hospital or by written agreement with a qualified provider of the service within one hour.
- (2) "Designated Primary Care Hospital" means a hospital designated by the North Carolina Office of Rural Health and

Resource Development in accordance with G.S. 131E-76(6).

- (3) "Federally Certified Primary Care Hospital" means a hospital which has been designated and certified as a Federally Certified Rural Primary Care Hospital under the Essential Access Community Hospital Program administered through the North Carolina Office of Rural Health and Resource Development in accordance with P.L. 101-239 and P.L. 101-508.
- (4) "Primary Care Inpatient Services" means that the hospital provides acute care inpatient services appropriate to the level of service at the facility up to a maximum annual average daily census of 15 patients per day. In addition, the hospital may also provide long term care in "swing bed" or distinct part status and psychiatric distinct part beds.

Statutory Authority G.S. 131E-76; 131E-79.

### .2103 LICENSURE APPLICATION

An application from a hospital seeking to be licensed under the rules of this Section must be accompanied by written certification from the North Carolina Office of Rural Health and Resource Development that the hospital is a Designated Primary Care Hospital or a Federally Certified Primary Care Hospital.

Statutory Authority G.S. 131E-76; 131E-79.

### .2104 FEDERALLY CERTIFIED PRIMARY CARE HOSPITAL

(a) The requirements of 10 NCAC 3C .0300 through .1699 and .1712(a) shall be waived for a hospital which the North Carolina Office of Rural Health and Resource Development certifies as a designated Federally Certified Primary Care Hospital, and Rule .1704(a) of that Subchapter shall not apply to such hospitals which do not provide emergency room service or maintain any life support systems.

(b) The Division reserves the right to conduct any validation survey or investigation of a specific complaint in hospitals which choose to be licensed as a Federally Certified Primary Care Hospital.

Statutory Authority G.S. 131E-76; 131E-79.

### .2105 DESIGNATED PRIMARY CARE HOSPITALS

The requirements of 10 NCAC 3C shall apply to Designated Primary Care Hospitals with the following modifications:

- (1) Autopsy facilities required in Rule .0704 of this Subchapter are not required for a Designated Primary Care Hospital, provided that the hospital has in effect a written agreement with another licensed hospital meeting Rule .0704 of this Subchapter for providing autopsy services.
- (2) Radiological services required in Section .0800 of this Subchapter are not required for Designated Primary Care Hospitals provided that the hospital has radiological equipment on site and a written agreement with another licensed hospital meeting the requirements of Section .0800 of this Subchapter which makes radiological service available.
- (3) Emergency services required in Section .1000 of this Subchapter are not required for Designated Primary Care Hospitals. Medical staff of a Designated Primary Care Hospital shall assure that hospital personnel are capable of initiating life saving measures at a first aid level of response for any patient or person in need of such services. This shall include:
  - (a) Establishing protocols or agreements with any hospital providing emergency services;
  - (b) Initiating basic cardio respiratory resuscitation according to the American Red Cross or American Heart Association standards;
  - (c) Availability of inter-veinous fluids and supplies required to establish inter-veinous access; and
  - (d) Availability of first line emergency drugs as specified by the medical staff.
- (4) Anesthesia services required in Section .1200 of this Subchapter are not required in Designated Primary Care Hospitals not offering outpatient surgery services.
- (5) Food services required in Section .1600 of this Subchapter must be provided for inpatients of Designated Primary Care Hospitals either directly or made available through contractual arrangements.

Statutory Authority G.S. 131E-76; 131E-79.

## SECTIONS .2200 - 2900 - RESERVED FOR FUTURE CODIFICATION

### SECTION .3000 - GENERAL INFORMATION

#### .3001 DEFINITIONS

The following definitions shall apply throughout this section, unless the text clearly indicates to the contrary:

- (1) "Appropriate" means suitable or fitting conforming to standards of care as established by professional organizations
- (2) "Approved" means acceptable to the authority having jurisdiction.
- (3) "Advanced Practice Nurse" means registered nurse with a graduate degree or advanced formal education in clinical nursing specialty who is credentialed by the Board of Nursing or the Board of Medical Examiners. This includes but is not limited to the Certified Registered Nurse Anesthetist (CRNA) and Certified Nurse Practitioner.
- (4) "Authority having jurisdiction" means the Division of Facility Services.
- (5) "Certified Dietary Manager" or "CDM" means an individual who is certified by the Certifying Board of the Dietary Managers and meets the standards and qualification as referenced in the "Dietary Manager Training Program Requirements." These standards include any subsequent amendments and editions of the referenced manual. Copies of the "Dietary Manager Training Program Requirements" may be purchased for fifteen dollars (\$15.00) from the Dietary Managers Association, One Pierce Place Suite 1220W, Itasca, Illinois 60143.
- (6) "Competence" means having the predetermined requisite abilities and qualities to perform specific functions.
- (7) "Comprehensive" means covering completely, inclusive.
- (8) "Continuous" means ongoing or uninterrupted, 24 hours per day.
- (9) "CRNA" means a Certified Registered Nurse Anesthetist as credentialed by the Council on Certification of Nurse Anesthetists, Board of Nursing, or the Board of Medical Examiners.
- (10) "Credentialed" means that the individual having a given title or position has been credited with the right to exercise official



- power.
- (11) "Department" means the Department of Human Resources.
- (12) "Departmentalized medical staff" means the divisions within the medical staff which separate specialties such as medicine, surgery, pediatrics, orthopedics.
- (13) "Dietetics" means the integration and application of principles derived from the science of nutrition, biochemistry, physiology, food and management and from behavioral and social sciences to achieve and maintain optimal nutritional status.
- (14) "Dietitian" means an individual who is licensed according to G.S. 90, Article 25, or is registered by the Commission on Dietetic Registration (CDR) of the American Dietetic Association (ADA) according to the standards and qualifications as referenced in the second edition of the "Accreditation/Approval Manual for Dietetic Education Programs", "The Registration Eligibility Application for Dietitians" and the "Continuing Professional Education" and subsequent amendments or editions of the reference material. Copies of the "Accreditation/Approval Manual for Dietetic Education Programs" may be purchased for twenty-one dollars and ninety-five cents (\$21.95) plus three dollars (\$3.00) minimum shipping and handling from ADA Sales Order Department, P.O. Box 97215, Chicago, IL 60678-7215.
- (15) "Dietetic Technician Registered" or "DTR" means an individual who is registered by the Commission on Dietetic Registration (CDR) of the American Dietetic Association (ADA) according to the standards and qualifications as referenced in the second edition of the "Accreditation/Approval Manual for Dietetic Education Programs". The Registration Eligibility Application for Dietetic Technicians" and the "Continuing Professional Education". Standards include any subsequent amendments and editions of the referenced material. Copies of the "Accreditation/Approval Manual for Dietetic Education Programs" may be purchased for \$21.95 plus \$3.00
- minimum for shipping and handling from the ADA Sales Order Department, P.O. Box 97215, Chicago, IL 60678-7215.
- (16) "Direct Supervision" means under the immediate management of a supervisor or other person of authority.
- (17) "Division" means the Division of Facility Services.
- (18) "Easily accessible" means the ability to enter, approach, communicate with or pass to and from, or to make use of without interference of physical barriers.
- (19) "Facility" means a hospital as defined in G.S. 131E-76.
- (20) "Free standing facility" means a facility that is physically separated from the primary hospital building or separated by a three hour fire containment wall.
- (21) "Full-time equivalent" means the method used to designate employee status for budget purposes; for accounting purposes this equals 2080 hours.
- (22) "Governing body" means the authority as defined in G.S. 131E-76.
- (23) "Imaging" means a reproduction or representation of a body or body part for diagnostic purposes by radiologic intervention that may include conventional fluoroscopic exam, magnetic resonance, nuclear or radio-isotope scan.
- (24) "Informed consent" means consent to health care treatment as defined in G.S. 90-21.13.
- (25) "Invasive procedure" means a procedure involving puncture or incision of the skin, insertion of an instrument or foreign material into the body (excluding venipuncture and intravenous therapy).
- (26) "LDRP" (labor, delivery, recovery, postpartum) means a specific single occupancy obstetrical use room counted as a licensed bed.
- (27) "License" means formal permission to provide services as granted by the State.
- (28) "Mission statement" means a written statement of the philosophy and beliefs of the organization or hospital as approved by the governing authority.
- (29) "Neonate" means the newborn from birth to one month.
- (30) "NP" means a Nurse Practitioner as defined in G.S. 90-6; 90-18(14) and 90-18.2.
- (31) "Nurse executive" means the director of nursing services or a representative of

- decentralized nursing management staff.
- (32) "Nurse midwife" means a Certified Nurse Midwife as defined in G.S. 90, Article 10.
- (33) "Nursing facility" means that portion of a hospital that is approved to provide skilled nursing care.
- (34) "Nutrition therapy" ranges from intervention and counseling on diet modification to administration of specialized nutrition therapies as determined necessary to manage a condition or treat illness or injury. Specialized nutrition therapies include supplementation with medical foods, enteral and parenteral nutrition. Nutrition therapy integrates information from the nutrition assessment with information on food and other sources of nutrients and meal preparation consistent with cultural background and socioeconomic status.
- (35) "Observation bed" means a bed used for a limited time, generally 24-72 hours, to evaluate and determine the condition and disposition of a patient and is not considered a part of the hospital's licensed bed capacity.
- (36) "PA" means a Physician Assistant as certified by the North Carolina Board of Medical Examiners.
- (37) "Patient" means any person admitted to the hospital for diagnostic services or nursing care.
- (38) "Physical Rehabilitation Services" means any combination of physical, occupational, speech therapy or vocational rehabilitation that meets the needs of the patient's served.
- (39) "Provisional license" means a hospital license recognizing significantly less than full compliance with the licensure rules.
- (40) "Qualification" means the conditions that must be complied with have been met (as the attainment of a privilege)
- (41) "Qualified" means having complied with the specific predetermined conditions for employment or the performance of a function.
- (42) "Reasonable" means not extreme, sensible.
- (43) "Reference" means to use in consultation to obtain information.
- (44) "Sound" means free from defect or damage; reliable.

- (45) "Special Care Unit" means a designated unit or area of a hospital with concentration of qualified professional staff and support services that provide intensive or extra ordinary care on a 24 hour basis to critically ill patients; the units may include but are not limited to Cardiac Care, Medical or Surgical Intensive Care Unit, Cardiothoracic Intensive Care Unit, Burn Intensive Care Unit, Neurologic Intensive Care Unit, Pediatric Intensive Care Unit.
- (46) "Substantial" means ample to satisfy a need; nourish; real or true; being that specific to a large degree or in the main.
- (47) "Substantially" means firmly, with strength or to a substantial degree.
- (48) "Unit" means a designated area of the hospital for the delivery of patient care services.

Statutory Authority G.S. 131E-79.

## SECTION .3100 - PROCEDURE

### .3101 GENERAL REQUIREMENTS

- (a) An application for licensure shall be submitted to the Division prior to a license being issued or patients admitted.
- (b) An existing facility shall not sell, lease, or subdivide a portion of its bed capacity without the approval of the Division.
- (c) Application forms may be obtained by contacting the Division.
- (d) The Division shall be notified in writing prior to the occurrence of any of the following:
- (1) addition or deletion of a licensable service;
  - (2) increase or decrease in bed capacity;
  - (3) change of chief executive officer;
  - (4) change of mailing address;
  - (5) ownership change; or
  - (6) name change.
- (e) Each application shall contain the following information:
- (1) legal identity of applicant;
  - (2) name or names under which the hospital or services are presented to the public;
  - (3) name of chief executive officer;
  - (4) ownership disclosure;
  - (5) bed complement;
  - (6) bed utilization;
  - (7) accreditation data;
  - (8) physical plant inspection data; and



- (9) service data.

*Statutory Authority G.S. 131E-79.*

## 02 PLAN APPROVAL

a) The facility design and construction shall be in accordance with the construction standards of the Division, the North Carolina Building Code, and local municipal codes.

b) Submission of Plans:

- (1) Before construction is begun, plans and specifications covering construction of the new buildings, alterations or additions to existing buildings, or any change in facilities shall be submitted to the Division for approval.
- (2) The Division will review the plans and notify the licensee that said buildings, alterations, additions, or changes are approved or disapproved if plans are disapproved the Division shall give the applicant notice of deficiencies identified by the Division.
- (3) In order to avoid unnecessary expense in changing final plans, a preliminary step, proposed plans in schematic form shall be reviewed by the Division.
- (4) The plans shall include a plot plan showing the size and shape of the entire site and the location of all existing and proposed facilities.
- (5) Plans shall be submitted in triplicate in order that the Division may distribute a copy to the Department of Insurance for review of State Building Code requirements and to the Department of Environmental Health Natural Resources for review under state sanitation requirements.

(c) Location:

- (1) The site for new construction or expansion shall be approved by the Division.
- (2) Hospitals shall be so located that they are free from undue noise from railroads, freight yards, main traffic arteries, schools and children's playgrounds.
- (3) The site shall not be exposed to smoke, foul odors, or dust from nearby industrial plants.
- (4) The area of the site shall be sufficient to permit future expansion and to provide adequate parking facilities.
- (5) The site shall be easily accessible.

- (6) Available paved roads, adequate water, sewage and power lines shall be taken into consideration in selecting the site.

(d) The bed capacity and services provided in a facility shall be in compliance with G.S. 131E, Article 9 regarding Certificate of Need. A facility shall be licensed for no more beds than the number for which required physical space and other required facilities are available. Neonatal Level II and III beds are considered beds for licensure purposes, but Level I (bassinets for newborns) are not considered part of licensed bed capacity.

*Statutory Authority G.S. 131E-79.*

## .3103 CLASSIFICATION OF MEDICAL FACILITIES

(a) The classification of "hospital" shall be restricted to facilities that provide as their primary functions diagnostic services and medical and nursing care in the treatment of acute stages of illness. On the basis of specialized facilities and services available, the Division shall license each such hospital according to the following medical types:

- (1) general acute care hospital;
- (2) rehabilitation hospital;
- (3) designated primary care hospital; or
- (4) federally certified primary care hospital.

(b) All other inpatient medical facilities accepting patients requiring skilled nursing services but which are not operated as a part of any hospital within the above meaning shall be considered to be operating as a nursing home and, therefore, are not subject to hospital licensure.

*Statutory Authority G.S. 131E-79.*

## .3104 LENGTH OF LICENSE

Licenses shall remain in effect for an indefinite period of time, unless the following occurs:

- (1) Division imposes an administrative sanction which specifies license expiration;
- (2) change of ownership;
- (3) closure;
- (4) change of site;
- (5) failure to comply with Rule .3105 of this Section.

*Statutory Authority G.S. 131E-79.*

## .3105 STATISTICAL INFORMATION

Utilization data shall be submitted annually upon

request by the Division. Forms for collection of this data will be forward to each facility by the Division.

Statutory Authority G.S. 131E-79.

### .3106 LICENSURE SURVEYS

(a) Prior to the initial issuance of a license to operate a facility, the Division shall conduct a survey to determine compliance with rules promulgated pursuant to G.S. 131E-79.

(b) The Division may conduct an investigation of a specific complaint in any facility.

(c) Facilities that are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) shall choose one of the following options:

(1) Accredited hospitals may agree to provide the Division with:

- (A) JCAHO Accreditation Certificate;
- (B) JCAHO Statement of Construction;
- (C) J C A H O Reports and Recommendations;
- (D) JCAHO Interim Self-Survey Reports; and
- (E) permission to participate in any regular survey conducted by the JCAHO.

If a review of the information listed in Subparagraphs (c)(1)(A) - (c)(1)(D) indicates non-compliance with licensure rules contained in this Subchapter, then the Division may conduct surveys or partial surveys with special emphasis on deficiencies noted. If a review indicates compliance with licensure regulations contained in this Subchapter, the Division will not conduct a licensure survey except as provided in Paragraphs (b), (c)(1)(E), and (d) of this Rule.

(2) Accredited hospitals which do not agree to provide the Division with JCAHO reports found in (c)(1) of this Rule shall be surveyed at least once every three years.

(d) The Division reserves the right to conduct any validation survey in facilities that choose the option under Subparagraph (c)(1) of this Rule.

(e) The Division shall survey non-accredited facilities at least once every three years.

Statutory Authority G.S. 131E-79.

### .3107 DENIAL, AMENDMENT OR

### REVOCATION OF LICENSE

(a) The Department may deny any licensure application upon becoming aware that the applicant is not in compliance with any applicable provision of the Certificate of Need law located in G.S. 131E, Article 9 and the rules adopted under the law.

(b) The Department may amend a license by reducing it from a full license to a provisional license whenever the Department finds that:

- (1) the licensee has failed to comply with the provisions of G.S. 131E, Article 9 and the rules promulgated under the article;
- (2) there is a probability that the licensee can remedy the licensure deficiency within a length of time not to exceed the expiration date on the license; and
- (3) there is a probability that the licensee will be able thereafter to remain in compliance with the hospital licensure rules for the foreseeable future.

(c) The Department shall also amend a license to provisional status by specifically prohibiting licensee from providing certain services, for which it has been found to be out of compliance with G.S. 131E, Articles 5 or 9. In all cases the Department shall give the licensee written notice of the amendment of the license. This notice shall be given by registered or certified mail or by personal service and shall set forth:

- (1) the length of the provisional license;
- (2) the factual allegations;
- (3) the statutes and rules alleged to be violated; and
- (4) notice of the facility's right to contested case hearing on the amendment of the license.

(d) The provisional license shall be effective immediately upon its receipt by the licensee and shall be posted in a prominent location, accessible to public view, within the licensed premises in lieu of the full license. The provisional license shall remain in effect until:

- (1) the Department restores the licensee to full licensure status;
- (2) the Department revokes the licensee's license; or
- (3) the end of the licensee's licensure period.

If a licensee has a provisional license at the time that the licensee submits a renewal application, the license, if renewed, shall also be a provisional license unless the Department determines that the licensee can be returned to full licensure status. A



decision to issue a provisional license is stayed during the pendency of an administrative appeal and the licensee may continue to display its full license during the appeal.

(e) The Department shall revoke a license whenever:

- (1) The Department finds that:
  - (A) the licensee has failed to comply with the provisions of G.S. 131E, Article 5 and the rules promulgated under that article; and
  - (B) it is not probable that the licensee can remedy the licensure deficiencies within a length of time acceptable to the Department; or
- (2) The Department finds that:
  - (A) The licensee has failed to comply with the provisions of G. S. 131E, Article 5; and
  - (B) although the licensee may be able to remedy the deficiencies within a reasonable time, it is not probable that the licensee will be able to remain in compliance with hospital licensure rules for the foreseeable future; or
- (3) The Department finds that the licensee has failed to comply with any of the provisions of G.S. 131E, Article 5 and the rules promulgated thereunder that endangers the health, safety or welfare of the patients in the facility.

The issuance of a provisional license is not a procedural prerequisite to the revocation of a license pursuant to Subparagraphs (d)(1), (2) or (3) of this Rule.

*Statutory Authority G.S. 131E-79.*

### **.3108 SUSPENSION OF ADMISSIONS**

(a) The Department may suspend the admission of any new patient to any facility when warranted under the provisions of G.S. 131E-78.

(b) The Department shall notify the facility by registered or certified mail or by personal service of the decision to suspend admissions. Such notice will include:

- (1) the period of the suspension;
- (2) factual allegations;
- (3) citation of statutes and rules alleged to be violated; and
- (4) notice of the facility's right to a contested case hearing.

(c) The suspension shall be effective when the notice is served or on the date specified in the notice of suspension, whichever is later. The

suspension shall remain effective for the period specified in the notice or until the facility demonstrates to the Department that conditions are no longer detrimental to the health and safety of the patient.

(d) The facility shall not admit new patients during the effective period of the suspension.

*Statutory Authority G.S. 131E-79.*

### **.3109 PROCEDURE FOR APPEAL**

A facility may appeal any decision of the Department to deny, revoke or amend a license or any decision to suspend admissions by making such an appeal in accordance with G.S. 150B.

*Statutory Authority G.S. 131E-79.*

### **.3110 ITEMIZED CHARGES**

(a) The facility shall either present an itemized list of charges to all discharged patients upon request or the facility shall include on patients' bills, which are not itemized, notification of the right to request an itemized bill within 30 days of receipt of the non-itemized bill.

(b) If requested, the facility shall present an itemized list of charges to each patient, or his responsible party.

(c) The itemized listing shall include, at a minimum, those charges incurred in the following service areas:

- (1) room rates;
- (2) laboratory;
- (3) radiology and nuclear medicine;
- (4) surgery;
- (5) anesthesiology;
- (6) pharmacy;
- (7) emergency services;
- (8) outpatient services;
- (9) specialized care;
- (10) extended care;
- (11) prosthetic and orthopedic appliances; and
- (12) other professional services.

*Statutory Authority G.S. 131E-79.*

## **SECTION .3200 - GENERAL HOSPITAL REQUIREMENTS**

### **.3201 HOSPITAL REQUIREMENTS**

A facility shall have all of the following:

- (1) an organized governing body;
- (2) a chief executive officer;
- (3) an organized medical staff;

- (4) an organized nursing staff;
- (5) continuous medical services;
- (6) continuous nursing services;
- (7) permanent on-site facilities for the care of patients 24 hours a day;
- (8) a hospital-wide infection control program;
- (9) minimum on-site clinical provisions as follows:
  - (a) appropriately equipped inpatient care areas;
  - (b) nursing care units;
  - (c) diagnostic and treatment areas to include on-site laboratory and imaging facilities with the capacity to provide immediate response to patient emergencies;
  - (d) pharmaceutical services in compliance with the Pharmacy Laws of North Carolina;
  - (e) facilities to assure the sterilization of equipment and supplies;
  - (f) medical records services;
  - (g) provision for social work services;
  - (h) current reference sources to meet staff needs; and
  - (i) nutrition services.
- (10) minimum supportive capabilities or facilities as follows:
  - (a) nutrition and dietetic services;
  - (b) scheduled general and preventive maintenance services for building, services and biomedical equipment;
  - (c) capability for obtaining police and fire protection, emergency transportation, grounds-keeping, and snow removal;
  - (d) personnel recruitment, training and continuing education;
  - (e) business management capability;
  - (f) short and long-range planning capability;
  - (g) financial plan to assure continuity of operation under both normal and emergency conditions;
  - (h) comprehensive policies and standards for assuring the safety of patients, employees, and visitors and for protection against malpractice and negligence; and
  - (i) comprehensive policies assuring that preventive and corrective maintenance is performed including procedures to be followed in the event of a breakdown of essential equipment.
- (11) facilities must comply with construction

rules in Sections .6000-.6200 of the Subchapter.

- (12) a risk management program as follows:
  - (a) a specific staff member shall assigned responsibility for development and administration of the program;
  - (b) a written policy statement evidencing current commitment to the risk management program together with written procedures, policies and educational programs applicable to the risk management program which are reviewed at least every three years and updated as necessary;
  - (c) established lines of communication between the risk management program and other functions relating to quality of patient care, safety, and professional staff performance; and
  - (d) a written report of the activities of the risk management program shall be annually submitted to the governing body.
- (13) a quality assessment and improvement program which provides:
  - (a) continuous assessment and evaluation of patient care and related services in all services and departments;
  - (b) a designated individual to coordinate the quality assessment and improvement program who will assist in the establishment of quality assessment and improvement plans and reporting methods for each service and department;
  - (c) a committee made up of representatives of the medical and nursing staff, administration, and other services of departments as defined by the hospital to coordinate the program, meet at least quarterly and maintain minutes of the meetings and committee activities; and
  - (d) for each service and department as defined by the hospital to be involved in the continuous assessment, monitoring and evaluation of patient care and related services.

Statutory Authority G.S. 131E-79.

## **.3202 ADMISSION AND DISCHARGE**

- (a) Facility management shall provide written admission and discharge, and referral policies.
- (b) There shall be on the premises at all times an employee authorized to receive patients and to



make administrative decisions on their disposition.

(c) A patient shall be admitted only under the care of a member of the medical staff meeting the provisions of Rule .4302 of this Subchapter.

(d) Facility management shall ensure that precautions are taken to ensure the safety and legal rights of all patients and employees.

(e) Facility management shall ensure that a complete and permanent record is maintained for all outpatients and inpatients including the date and time of admission and discharge. Effort shall be made to verify the full and true name, address, date of birth, nearest of kin, provisional diagnosis, condition on admission and discharge, referring physicians, attending physician or service.

(f) Facility staff shall provide at the time of admission an identification bracelet, band, or other suitable device for positive identification of each patient.

(g) No mentally competent adult shall be detained by the facility against his will, nor shall a child be detained against the will of a parent or legal guardian. This restriction shall not apply to persuasion of the patient in his own interest to consider the possible consequences of his action, nor to the temporary detention of a mentally disturbed patient for the protection of himself and others, pending prompt legal disposition as may be provided for in G.S. 122C. Documentation of the commitment process shall be retained for all involuntary commitments in accordance with the provisions of Rule .4503 of this Subchapter.

*Statutory Authority G.S. 131E-79.*

### **.3203 DISCHARGE PLANNING**

(a) Facility management shall ensure that discharge planning is an integral part of in-patient hospitalization.

(b) Facility management shall have written policies and procedures governing discharge planning. These shall include but need not be limited to the following:

- (1) appropriate screening to determine the need for discharge planning;
- (2) methods to facilitate the provision of follow-up care;
- (3) information to be given to the patient or his family or other persons involved in caring for the patient on matters such as the patient's condition; his health care needs; the amount of activity he should engage in; any necessary medical regimens including drugs, nutrition therapy, appointments or other forms of

therapy; sources of additional help from other agencies; and procedures to follow in case of complications; and procedures for assisting the patient and his family in gaining information regarding financial assistance in paying bills incurred as a result of the hospitalization, including how to receive assistance from the various federal and State government programs.

(4)

*Statutory Authority G.S. 131E-79.*

### **.3204 TRANSFER AGREEMENT**

(a) Any facility which does not provide hospital based nursing facility service shall maintain written agreements with institutions offering this kind of care. Such agreements shall provide for the transfer and admission of patients who no longer require the services of the hospital but do require nursing facility services.

(b) A patient shall not be transferred to another medical care facility unless prior arrangements for admission have been made. Clinical records of sufficient content to insure continuity of care shall accompany the patient.

*Statutory Authority G.S. 131E-79.*

### **.3205 DISCHARGE OF MINOR OR INCOMPETENT**

Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, legal guardian, person standing in loco parentis, or another responsible party unless otherwise directed by the parent or guardian or court of competent jurisdiction. If the parent or guardian directs that discharge be made otherwise, he shall so state in writing, and the statement shall become a part of the permanent medical record of the patient.

*Statutory Authority G.S. 131E-79.*

## **SECTION .3300 - PATIENT'S BILL OF RIGHTS**

### **.3301 PRINCIPLE**

It is the purpose of these requirements to promote the interests and well-being of the patients in facilities subject to this Subchapter even in those instances where the interests of the patients may be in opposition to the interests of the facility. The facility has the right to expect the patient to fulfill patient responsibilities as may be stated in the

facilities' policies affecting patient care and conduct.

Statutory Authority G.S. 131E-79.

### .3302 MINIMUM PROVISIONS OF PATIENT'S BILL OF RIGHTS

(a) A patient has the right to respectful care given by competent personnel.

(b) A patient has the right, upon request, to be given the name of his attending physician, the names of all other physicians directly participating in his care, and the names and functions of other health care persons having direct contact with the patient.

(c) A patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are considered confidential and should be conducted discreetly.

(d) A patient has the right to have all records pertaining to his medical care treated as confidential except as otherwise provided by law or third party contractual arrangements.

(e) A patient has the right to know what facility rules and regulations apply to his conduct as a patient.

(f) The patient has the right to expect emergency procedures to be implemented without unnecessary delay.

(g) The patient has the right to good quality care and high professional standards that are continually maintained and reviewed.

(h) The patient has the right to full information in laymen's terms, concerning his diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. When it is not possible or medically advisable to give such information to the patient, the information shall be given on his behalf to the patient's next of kin or other appropriate person.

(i) Except for emergencies, the physician must obtain the necessary informed consent prior to the start of any procedure or treatment, or both.

(j) A patient has the right to be advised when a physician is considering the patient as a part of a medical care research program or donor program. Informed consent must be obtained prior to actual participation in such program and the patient or legally responsible party, may, at any time, refuse to continue in any such program to which he has previously given informed consent.

(k) A patient has the right to refuse any drugs, treatment or procedure offered by the facility, to

the extent permitted by law, and a physician shall inform the patient of his right to refuse any drugs treatment or procedures and of the medical consequences of the patient's refusal of any drugs treatment or procedure.

(l) A patient has the right to assistance in obtaining consultation with another physician at the patient's request and expense.

(m) A patient has the right to medical and nursing services without discrimination based upon race, color, religion, sex, sexual preference, national origin or source of payment.

(n) A patient who does not speak English shall have access, when possible, to an interpreter.

(o) The facility shall provide the patient, or patient designee, upon request, access to all information contained in his medical records unless access is specifically restricted by the attending physician. If the physician restricts the patient's access to information in his medical record, the physician shall record the reasons on the patient's medical record. Access shall be restricted only for sound medical reason.

(p) The patient has the right to expect management techniques to be implemented within the facility considering effective use of the time of the patient and to avoid the personal discomfort of the patient.

(q) When medically permissible, a patient may be transferred to another facility only after he or his next of kin or other legally responsible representative has received complete information and an explanation concerning the needs for and alternatives to such a transfer. The facility to which the patient is to be transferred must first have accepted the patient for transfer.

(r) The patient has the right to examine and receive a detailed explanation of his bill.

(s) The patient has a right to full information and counseling on the availability of known financial resources for his health care.

(t) A patient has the right to expect that the facility will provide a mechanism whereby he is informed upon discharge of his continuing health care requirements following discharge and the means for meeting them.

(u) A patient cannot be denied the right of access to an individual or agency who is authorized to act on his behalf to assert or protect the rights set out in this Section.

(v) A patient has the right to be informed of his rights at the earliest possible time in the course of his hospitalization.

Statutory Authority G.S. 131E-79.



**.3303 PROCEDURE**

(a) Facility management shall develop and implement procedures to inform each patient of his rights. Copies of the facilities' Patient's Bill of Rights shall be made available through one of the following ways:

- (1) prominent displays in appropriate locations in addition to copies available upon request; or
- (2) provision of a copy to each patient or responsible party upon admission or as soon after admission as is feasible.

(b) The address and telephone number of the section in the Department responsible for the enforcement of the provisions of this part shall be posted.

(c) Facility management shall adopt procedures to ensure effective and fair investigation of violations of patients' rights and to ensure their enforcement. These procedures shall ensure that:

- (1) a system is established to identify formal written complaints;
- (2) formal written complaints are recorded and investigated;
- (3) investigation and resolution of formal complaints shall be conducted; and
- (4) disciplinary and education procedures shall be developed for members of the hospital and medical staff who consistently cause patient relationship problems.

(d) The Division shall investigate or refer to appropriate State agencies all complaints within the jurisdiction of the rules in this Subchapter.

*Statutory Authority G.S. 131E-79.*

**SECTION .3400 - SUPPLEMENTAL  
RULES FOR THE LICENSURE  
OF DESIGNATED PRIMARY CARE  
HOSPITALS AND FEDERALLY  
CERTIFIED PRIMARY CARE HOSPITALS**

**.3401 SUPPLEMENTAL RULES**

The rules of this Section pertain only to designated Primary Care Hospitals or Federally Certified Primary Care Hospitals. The general requirements of this Subchapter shall apply to such facilities except where they are specifically waived or modified by the rules of this Section.

*Statutory Authority G.S. 131E-79.*

**.3402 DEFINITIONS**

The following definitions shall apply throughout

this Section, unless text otherwise clearly indicates to the contrary:

- (1) "Available" means provided directly by the facility or by written agreement with a qualified provider of the service within one hour.
- (2) "Designated Primary Care Hospital" means a facility designated by the North Carolina Office of Rural Health and Resource Development in accordance with G.S. 131E-76(6).
- (3) "Federally Certified Primary Care Hospital" means a hospital which has been designated and certified as a Federally Certified Rural Primary Care Hospital under the Essential Access Community Hospital Program administered through the North Carolina Office of Rural Health and Resource Development in accordance with P.L. 101-239 and P.L. 101-508.
- (4) "Primary Care Inpatient Services" means that the hospital provides acute care inpatient services appropriate to the level of service at the facility up to a maximum annual average daily census of 15 patients per day. In addition, the facility may also provide long term care in "swing bed" or distinct part status and psychiatric distinct part beds.

*Statutory Authority G.S. 131E-79.*

**.3403 LICENSURE APPLICATION**

An application from a facility seeking to be licensed under the rules of this Section must be accompanied by written certification from the North Carolina Office of Rural Health and Resource Development that the facility is a Designated Primary Care Hospital or a Federally Certified Primary Care Hospital.

*Statutory Authority G.S. 131E-79.*

**.3404 FEDERALLY CERTIFIED  
PRIMARY CARE HOSPITAL**

(a) The requirements of 10 NCAC 3C .3500 through .5206 shall be waived for a facility which the North Carolina Office of Rural Health and Resource Development certified as a designated Federally Certified Primary Care Hospital, and Rule .6227 (f) and (g) of that Subchapter shall not apply to such facilities which do not provide emergency room service or maintain any life support systems.

(b) The Division reserves the right to conduct any validation survey or investigation of a specific complaint in facilities which choose to be licensed as a Federally Certified Primary Care Hospital.

*Statutory Authority G.S. 131E-79.*

### **.3405 DESIGNATED PRIMARY CARE HOSPITALS**

The requirements of 10 NCAC 3C shall apply to Designated Primary Care Hospitals with the following modifications:

- (1) Autopsy facilities required in Rule .4907 of this Subchapter are not required for a Designated Primary Care Hospital, provided that the facility has in effect a written agreement with another facility meeting Rule .4907 of this Subchapter for providing autopsy services.
- (2) Radiological services required in Section .4800 of this Subchapter are not required for Designated Primary Care Hospitals provided that the facility has radiological equipment on site and a written agreement with another licensed facility meeting the requirements of Section .4800 of this Subchapter which makes radiological service available.
- (3) Emergency services required in Section .4100 of this Subchapter are not required for Designated Primary Care Hospitals. Medical staff of a Designated Primary Care Hospital shall assure that facility personnel are capable of initiating life-saving measures at a first-aid level of response for any patient or person in need of such services. This shall include:
  - (a) Establishing protocols or agreements with any facility providing emergency services;
  - (b) Initiating basic cardio-respiratory resuscitation according to the American Red Cross or American Heart Association standards;
  - (c) Availability of intravenous fluids and supplies required to establish intravenous access; and
  - (d) Availability of first-line emergency drugs as specified by the medical staff.
- (4) Anesthesia services required in Section .4600 of this Subchapter are not required in Designated Primary Care Hospitals not offering outpatient surgery services.
- (5) Food services required in Section .4700

of this Subchapter shall be provided for inpatients of Designated Primary Care Hospitals either directly or made available through contractual arrangements.

*Statutory Authority G.S. 131E-79.*

### **SECTION .3500 - GOVERNANCE AND MANAGEMENT**

#### **.3501 GOVERNING BODY**

(a) The governing body, owner or the person or persons designated by the owner as the governing authority shall be responsible for seeing that the objectives specified in the charter (or resolution if publicly owned) are attained.

(b) The governing body shall be the final authority in the facility to which the administrator, the medical staff, the personnel and all auxiliary organizations are directly or indirectly responsible.

(c) A local advisory board shall be established if the facility is owned or controlled by an organization or persons outside of North Carolina.

*Statutory Authority G.S. 131E-79.*

#### **.3502 BYLAWS**

(a) The governing body shall adopt bylaws in accordance with all requirements contained in this subchapter and in accordance with the community responsibility of the facility. As a minimum, the bylaws shall do the following:

- (1) state the general and specific goals of the facility;
- (2) describe the powers and duties of the governing body officers and committee and the responsibilities of the chief executive officer;
- (3) state the qualifications for governing body membership, the procedures for selecting members, and the terms of service for members, officers and committee chairmen;
- (4) describe the authority delegated to the chief executive officer and to the medical staff. No assignment, referral or delegation of authority by the governing body shall relieve the governing body of its responsibility for the conduct of the facility. The governing body shall retain the right to rescind any such delegation;
- (5) require Board approval of the bylaws of any auxiliary organizations established



- by the hospital;
- (6) require the governing body to review and approve the bylaws of the medical staff organization;
- (7) establish a procedure for processing and evaluating the applications for medical staff membership and for the granting of clinical privileges;
- (8) establish a procedure for implementing, disseminating, and enforcing a Patient's Bill of Rights in compliance with G.S. 131E-117; and
- (9) require the governing body to institute procedures to ensure:
  - (A) orientation of newly elected board members to specific board functions and procedures;
  - (B) the development of procedures for periodic reexamination of the relationship of the board to the total facility community; and
  - (C) the recording of minutes of all governing body and executive committee meetings and the dissemination of those minutes, or summaries thereof, on a regular basis to all members of the governing body.
- (b) The bylaws shall be reviewed at least every three years, revised as necessary, and dated to indicate when last reviewed or revised.

Statutory Authority G.S. 131E-79.

### 3503 FUNCTIONS

The governing body, with technical assistance and advice from the facility staff, shall be responsible for the following:

- (1) provide management, physical resources and personnel required to meet the needs of the patients for which it is licensed;
- (2) require management to establish a quality control mechanism which includes as an integral part a risk management component and an infection control program;
- (3) formulate short-range and long-range plans for the development of the facility;
- (4) conform to all applicable federal, State and local laws and regulations;
- (5) provide for the control and use of the physical and financial resources of the facility;
- (6) review the annual audit, budget and periodic reports of the financial operations of the facility;

- (7) utilize the advice of the medical staff in granting and defining the scope of clinical privileges to individuals. When the governing body does not concur in the medical staff recommendation regarding the clinical privileges of an individual, there shall be a review of the recommendation by a joint committee of the medical staff and governing body before a final decision is reached by the governing body;
- (8) require that applicants be informed of the disposition of their application for medical staff membership or clinical privileges, or both, within an established period of time after their application has been submitted;
- (9) review and approve the medical staff by-laws, rules and regulations body;
- (10) delegate to the medical staff the authority to evaluate the professional competence of staff members and applicants for staff privileges and hold the medical staff responsible for recommending initial staff appointments, reappointments and assignments or curtailments of privileges;
- (11) require that resources be made available to address the emotional and spiritual needs of patients either directly or through referral or arrangement with community agencies;
- (12) maintain effective communication with the medical staff which shall be established, through:
  - (a) meetings with the Executive Committee of the Medical Staff;
  - (b) service by the president of the medical staff as a member of the governing body with or without a vote;
  - (c) appointment of individual medical staff members to governing body committees; and
  - (d) a joint conference committee.
- (13) require the medical staff to establish controls that are designed to ensure standards of ethical professional practices;
- (14) ensure that the medical staff is provided with the necessary staff support to facilitate utilization review and infection control within the facility and to support quality control, any other medical staff functions required by this subchapter or by the facility bylaws;
- (15) ensure that the following public

- disclosure requirements are being met:
- (a) data required by the North Carolina Medical Data Base Commission and the Division;
  - (b) the facilities' average daily inpatient charge upon request; and
  - (c) public disclosure of the persons owning 5.0 percent or more of the facility as well as the facilities officers and members of the governing body.
- (16) establish a procedure for reporting the occurrence and disposition of any unusual incidents which will assure that:
- (a) incident reports are analyzed and summarized; and
  - (b) corrective action is taken as indicated by the analysis of incident reports;
- (17) in a facility with one or more units, or portions of units, however described, utilized for psychiatric or substance abuse treatment adopt policies implementing the provisions of G.S. 122C, Article 3, and Article 5, Parts 2, 3, 4, 5, 7, and 8;
- (18) develop arrangements for the provision of extended care and other long-term healthcare services. Such services shall be provided in the facility or by outside resources through a transfer agreement or referrals;
- (19) provide and implement a written plan for the care or for the referral, or for both, of patients who require mental health or substance abuse services while in the hospital;
- (20) develop a conflict of interest policy which shall apply to all governing body members and corporate officers. All governing body members shall execute a conflict of interest statement;
- (21) ensure members of the governing body shall not engage in the following forms of self-dealing:
- (a) the sale, exchange or leasing of property of services between the facility and a governing board member, his employer or an organization substantially controlled by him on a basis less favorable to the facility than that on which such property or service is made available to the general public;
  - (b) furnishing of goods, services or facilities by a facility to a governing board member, unless such furnishing is made on a basis not more favorable than that on which such goods,

services, or facilities are made available to the general public or employees of the facility; or

- (c) any transfer to or use by or for the benefit of a governing board member of the income or assets of a facility except by purchase for fair market value; and

(22) prohibit the lease, sale, or exclusive use of any facility buildings or facilities receiving a license in accordance with this subchapter to any entity which provides medical or other health services to the facility's patients, unless there is full, complete disclosure to and approval from the Division.

*Statutory Authority G.S. 131E-79.*

## SECTION .3600 - MANAGEMENT AND ADMINISTRATION OF OPERATIONS

### .3601 CHIEF EXECUTIVE OFFICER

The governing body shall designate a chief executive officer whose qualifications, authority, responsibilities and duties shall be defined in a written statement adopted by the governing body.

*Statutory Authority G.S. 131E-79.*

### .3602 RESPONSIBILITIES

(a) The chief executive officer shall be the designated representative of the governing body.

(b) The chief executive officer shall:

- (1) designate an individual to act for him in his absence;
- (2) manage the facility commensurate with the authority conferred on him by the governing body and consonant with its expressed aims and policies;
- (3) attend meetings of the governing body and appropriate meetings of the medical staff;
- (4) implementation of policies adopted by the governing body for the operation of the facility;
- (5) organize the administrative functions of the facility, delegate duties and establish formal means of accountability on the part of subordinates;
- (6) establish such facility departments as are indicated, provide for departmental and interdepartmental meetings and attend or be represented at such meetings, and appoint hospital depart



- mental representatives to medical staff committees where appropriate or when requested to do so by the medical staff;
- (7) appoint the heads of administrative departments;
  - (8) report to the governing body and to the medical staff on the overall activities of the facility as well as on appropriate federal, State and local developments that affect health care in the facility;
  - (9) review the annual audit of the financial operations of the facility and acting upon recommendations therein;
  - (10) provide fiscal planning and financial management of the facility including the provision of annual budgets and periodic financial status reports to the governing board;
  - (11) develop in cooperation with the departmental heads and other appropriate staff, an overall organizational plan for the facility which will coordinate the functions, services and departments of the facility, when possible; and
  - (12) ensure that the agreements with service providers, such as laundry, laboratory and imaging, specifically indicate that compliance will be maintained with applicable State rules as would apply to the same services if provided directly by the facility.

*Statutory Authority G.S. 131E-79.*

### **.3603 PERSONNEL POLICIES AND PRACTICES**

The chief executive officer shall ensure that personnel policies and practices which support sound patient care are established and maintained. The policies shall be in writing and made available to all employees, and they shall be reviewed periodically but no less often than once every three years. The date of the most recent review shall be indicated on the written policies. A procedure shall be established for notifying employees of changes in the established personnel policies.

*Statutory Authority G.S. 131E-79.*

### **.3604 JOB DESCRIPTIONS**

Facility management shall ensure that a written job description for each type of job in the facility, including the chief executive officer and heads of departments, is developed and made available to

the employee.

*Statutory Authority G.S. 131E-79.*

### **.3605 PERSONNEL RECORDS**

(a) Facility management shall maintain accurate and complete personnel records for each facility employee during his term of employment and for two years thereafter. The chief executive officer may designate an individual to carry out this assignment.

(b) Personnel records shall contain at least the following:

- (1) information regarding the employee's education, training and experience, including, if applicable, professional licensure status and license number, sufficient to verify the employee's qualifications for the job for which he is employed. Such information shall be kept current. Applicants for positions requiring a licensed person shall be hired only after obtaining verification of their licenses from the appropriate board;
- (2) current information relative to periodic work performance evaluations;
- (3) records of such pre-employment health examinations and of subsequent health services rendered to the employees as are necessary to ensure that all facility employees are physically able to perform their duties; and
- (4) reports verifying that reasonable precautions have been taken to ensure the absence of detectable active communicable disease as defined by the North Carolina Department of Environment, Health and Natural Resources.

*Statutory Authority G.S. 131E-79.*

### **.3606 EDUCATION PROGRAMS**

Facility management shall provide new employee orientation and continuing education programs for all employees to maintain the skills necessary for the performance of their duties and learn new developments in health care. Records shall be maintained of all orientation and educational programs, and of the participants.

*Statutory Authority G.S. 131E-79.*

### **.3607 PERSONNEL HEALTH**

## REQUIREMENTS

Employees shall have pre-employment medical examinations and interim examinations in accordance with medically acceptable criteria.

*Statutory Authority G.S. 131E-79.*

### .3608 INSURANCE

The governing board shall have in place an insurance program which provides for the protection of the physical and financial resources of the facility. There shall be appropriate coverage of the building and equipment and adequate comprehensive liability insurance or an equivalent self-insurance plan covering members of the governing board and appropriate medical and administrative personnel.

*Statutory Authority G.S. 131E-79.*

### .3609 AUDIT OF FINANCIAL OPERATIONS

An audit of the financial operations of the facility shall be performed by a public accountant at least once a year.

*Statutory Authority G.S. 131E-79.*

## SECTION .3700 - MEDICAL STAFF

### .3701 GENERAL PROVISIONS

The facility shall have an organized medical staff which shall be accountable to the governing body and which shall have responsibility for the quality of professional services provided by individuals with clinical privileges. Facility management shall have a mechanism to ensure that individuals with clinical privileges provide services within the scope of individual privileges granted.

*Statutory Authority G.S. 131E-79.*

### .3702 COMPOSITION

The medical staff shall be established in accordance with the by-laws, rules and regulations of the medical staff and with the by-laws of the facility. The governing body of the facility, after considering the recommendations of the medical staff, may grant clinical privileges to other qualified, licensed practitioners in accordance with their training, experience, and demonstrated competence and judgment in accordance with the medical staff by-laws.

*Statutory Authority G.S. 131E-79.*

### .3703 APPOINTMENT AND REAPPOINTMENT

Formal appointment for membership and granting of clinical privileges shall follow established procedures set forth in the by-laws, rules and regulations of the medical staff. These procedures shall require the following:

- (1) a signed application for membership, specifying age, year and school of graduation, date of licensure, statement of postgraduate or special training and experience with a statement of the scope of the clinical privileges sought by the applicant;
- (2) verification by the hospital of the qualifications of the applicant as stated in the application, including evidence of continuing education;
- (3) written notice to the applicant from the medical staff and the governing body, regarding appointment or reappointment which specifies the approval or denial of clinical privileges and the scope of the privileges granted; and
- (4) members of the medical staff and others granted clinical privileges in the facility shall hold current licenses to practice in North Carolina.

*Statutory Authority G.S. 131E-79.*

### .3704 STATUS

(a) Every facility shall have an active medical staff to deliver medical services within the facility. The active medical staff shall be responsible for its own organization and administration. Every member of the active medical staff shall be eligible to vote at staff meetings and to hold office.

(b) The medical staff shall determine categories for membership which shall be identified and defined in the medical staff bylaws. Examples are:

- (1) active medical staff;
- (2) associate medical staff;
- (3) courtesy medical staff;
- (4) temporary medical staff;
- (5) consulting medical staff;
- (6) honorary medical staff; or
- (7) other staff classifications.

(c) Medical staff appointments shall be reviewed at least once every two years by the governing board.

(d) Facility management shall maintain an individual file for each medical staff member. Representatives of the Department shall have access to these files in accordance with G.S. 131E-



80.

(e) Minutes of all actions taken by the medical staff and the governing board concerning the privileges granted shall be maintained.

*Statutory Authority G.S. 131E-79.*

### **.3705 MEDICAL STAFF BYLAWS, RULES AND REGULATIONS**

(a) The medical staff shall develop and adopt, subject to the approval of the governing body, a set of bylaws, rules and regulations, to establish a framework for self governance of medical staff activities and accountability to the governing body.

(b) The medical staff bylaws, rules and regulations shall provide for at least the following:

- (1) organizational structure;
- (2) qualifications for staff membership;
- (3) procedures for admission, retention, assignment, and reduction or withdrawal of privileges;
- (4) procedures for fair hearing and appellate review mechanisms for denial of staff appointments, reappointments, suspension, or revocation of clinical privileges;
- (5) composition, functions and attendance of standing committees;
- (6) policies for completion of medical records and procedures for disciplinary actions;
- (7) formal liaison between the medical staff and the governing body;
- (8) methods developed to formally verify that each medical staff member on appointment or reappointment agrees to abide by current medical staff bylaws and facility bylaws; and
- (9) procedures for members of medical staff participation in quality assurance functions.

*Statutory Authority G.S. 131E-79.*

### **.3706 ORGANIZATION AND RESPONSIBILITIES OF THE MEDICAL STAFF**

(a) The medical staff shall be organized to accomplish its required functions and provide for the election or appointment of its officers.

(b) There shall be an executive committee, or its equivalent, which represents the medical staff, which has responsibility for the effectiveness of all medical activities of the staff, and which acts for the medical staff.

(c) All minutes of proceedings of medical staff committees shall be recorded and available for inspections by members of the medical staff and the governing body.

(d) The following reviews and functions shall be performed by the medical staff:

- (1) credentialing review;
- (2) surgical case review;
- (3) medical records review;
- (4) medical care evaluation review;
- (5) drug utilization review;
- (6) radiation safety review;
- (7) blood usage review; and
- (8) bylaws review.

(e) There shall be medical staff and departmental meetings for the purpose of reviewing the performance of the medical staff, departments or services, and reports and recommendations of medical staff and multi-disciplinary committees. The medical staff shall ensure that minutes are taken at each meeting and retained in accordance with the policy of the facility. These minutes shall reflect the transactions, conclusions and recommendations of the meetings.

*Statutory Authority G.S. 131E-79.*

### **.3707 MEDICAL ORDERS**

(a) No medication or treatment shall be administered or discontinued except in response to the order of a member of the medical staff in accordance with established rules and regulations.

(b) Such orders shall be dated and recorded directly in the patient chart or in a computer or data processing system which provides a hard copy printout of the order for the patient chart. A method shall be established to safeguard against fraudulent recordings.

(c) All orders for medication or treatment shall be authenticated at the time of recordation by the ordering member of the medical staff except as specified in Paragraph (e) of this Rule. Authentication must be accomplished by signature, initials, computer entry or code or other methods not inconsistent with the laws, rules and regulations of any other applicable jurisdictions.

(d) The names of drugs shall be recorded in full and not abbreviated.

(e) Verbal orders shall be taken and transcribed in the patient's medical record by personnel qualified according to medical staff rules. The transcription of medical orders shall be described in the medical staff by-laws and departmental policy. The order shall include the date, time, and full signature of the person taking the order and shall

be countersigned by a physician within 24 hours. Authentication must be accomplished by signature, initials, computer entry code, or other methods not inconsistent with the laws, rules and regulations of any other applicable jurisdictions.

(f) The medical staff shall establish a written policy in conjunction with the pharmacy committee or its equivalent for all medications not specifically prescribed as to time or number of doses to be automatically stopped after a reasonable time limit, but no more than 14 days. The prescriber shall be notified according to established policies and procedures at least 24 hours before an order is automatically stopped.

Statutory Authority G.S. 131E-79.

### .3708 MEDICAL STAFF RESPONSIBILITIES FOR QUALITY IMPROVEMENT REVIEW

(a) The medical staff shall have in effect a system to review medical services rendered, to assess quality, to provide a process for improving performance when indicated and to monitor the outcome.

(b) The medical staff shall establish criteria for the evaluation of the quality of medical care.

(c) Facility management shall have a written plan approved by the medical staff, administration and governing body which generates reports to permit identification of patient care problems. The plan shall establish a system to use this data to document and identify interventions.

(d) The medical staff shall ensure that there is a continuous review process of the care rendered to both inpatients and outpatients in every medical department of the facility. At least quarterly, the medical staff shall have a meeting to review the process and results. The review process shall include both practitioners and allied health professionals from the facility staff.

(e) Minutes shall be taken at all meetings reviewing quality improvement, and these minutes shall be made available to the medical staff on a regular basis in accordance with established policy. These minutes shall be retained as determined by the facility.

Statutory Authority G.S. 131E-79.

## SECTION .3800 - NURSING SERVICES

### .3801 NURSE EXECUTIVE

(a) If the facility utilizes a 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 and procedures that describe how the nursing care needs of patients are assessed, evaluated and met.

(c) The nurse executive shall develop and adopt subject to the approval of facility management, a set of administrative policies and procedures to establish a framework to accomplish required functions.

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

(e) The nurse executive shall be responsible for

- (1) the development of a written organizational plan which describes the levels of accountability and responsibility within the nursing organization;
- (2) identification of standards and policies and procedures related to the delivery of nursing care;
- (3) planning for and the evaluation of the delivery of nursing care delivery system;
- (4) establishment of a mechanism to validate qualifications, knowledge, and skills of nursing personnel;
- (5) provision of orientation and educational opportunities related to expected nursing performance; and
- (6) implementation of a system for performance evaluation.

(f) The nurse executive shall ensure that nursing care services are provided in conformance with the North Carolina Nursing Practice Act.

(g) The nurse executive shall ensure that each member of the nursing staff is assigned clinical and or managerial responsibilities based upon educational preparation, in conformance with licensing laws and an assessment of current competence. Orientation and continuing education records shall be maintained.

(h) Nurse executives shall ensure that staffing is based on a patient classification system which reflects the number of nursing personnel required for each patient unit.

Statutory Authority G.S. 131E-79.

### .3802 NURSING STAFF

(a) Licensed nurses and other nursing personnel shall be qualified by training, education,



experience and demonstrated abilities to provide nursing care within their scope of practice.

(b) Staffing schedules which reflect personnel assignment by date and service unit shall be kept on file for at least three years by hospital management.

(c) Facility management shall establish policies for the provision of services for all contractual agreement personnel that include at a minimum the following:

- (1) verification of licensure or certification by the appropriate occupational board;
- (2) delivery and documentation of care;
- (3) participation on interdisciplinary care planning activities; and
- (4) supervision of contractual agreement personnel.

*Statutory Authority G.S. 131E-79.*

### **.3803 NURSING POLICIES AND PROCEDURES**

(a) A nurse executive shall ensure that nursing care policies and procedures are available to the nursing staff in each nursing care unit and service area. Nursing policies and procedures shall include the following:

- (1) method of noting diagnostic and therapeutic orders;
- (2) method of assigning nursing care of patients;
- (3) infection control measures;
- (4) patient safety measures; and
- (5) method of implementing orders for medication or treatment.

(b) Each unit shall have relevant clinical reference materials available. The following shall be provided to each unit:

- (1) a facility formulary or comparable drug reference;
- (2) a policy and procedure manual; and
- (3) a medical dictionary.

(c) Facility management shall provide a program of inservice education which shall be maintained and documented for all nursing service personnel. Annual inservices shall include infection control measures, cardiopulmonary resuscitation and fire and safety.

(d) Nursing care policies and procedures shall be reviewed at least every three years by the nursing staff and facility management and revised as necessary. They shall include the date to indicate the time of the most recent review or revision.

*Statutory Authority G.S. 131E-79.*

### **.3804 PATIENT CARE**

(a) Each patient's need for nursing care related to his or her admission shall be determined by a registered nurse. Patient needs shall be reassessed when warranted by the patient's condition.

(b) Each patient's nursing care shall be based upon patient needs and shall be coordinated with the therapies of other disciplines.

(c) The patient's medical record shall include documentation of:

- (1) the initial assessment and reassessments of patient clinical status;
- (2) patient care needs;
- (3) interventions identified to meet the patient's nursing care needs;
- (4) implementation of physician's orders;
- (5) the nursing care provided; and
- (6) the patient's response to, and the outcomes of, the care provided.

(d) Each plan of care shall be initiated within 24 hours of admission. The plan of care shall become a part of the clinical record.

(e) The nursing care plan shall be readily available to all physicians and facility personnel involved with the care of the patient.

*Statutory Authority G.S. 131E-79.*

## **SECTION .3900 - MEDICAL RECORD SERVICES**

### **.3901 ORGANIZATION**

(a) Facility management shall establish a medical record service. It shall be directed, staffed and equipped to ensure the accurate processing, indexing and filing of all medical records. Orientation, on-the-job training and inservice programs for medical records personnel shall be provided.

(b) The medical record service shall be equipped to enable its personnel to maintain medical records so that they are readily accessible and secure from unauthorized use.

*Statutory Authority G.S. 131E-79.*

### **.3902 MANAGER**

(a) The medical records service shall be directed and supervised by a qualified medical records manager. If the manager is not a registered record administrator or an accredited records technician, the facility shall retain a person with those qualifications on a part-time or consulting basis.

(b) The manager of the medical record service shall advise, administer, supervise and perform work involved in the development, analysis, maintenance and use of medical records and reports.

(c) Where the manager is employed on a part-time or consulting basis, he or she shall organize the department, train the regular personnel and make periodic visits to the facility. The manager shall evaluate the records and the operation of the service and document the visits by written reports. A written contract specifying his or her duties and responsibilities shall be kept on file and made available for inspection by the Division's surveyor.

(d) The manager of the medical record service shall maintain a system of identification and filing to facilitate the prompt location of medical record of any patient.

(e) The manager of the medical records service shall ensure that medical records are stored in such a manner as to provide protection from loss, damage, and unauthorized access.

*Statutory Authority G.S. 131E-79.*

### **.3903 PRESERVATION OF MEDICAL RECORDS**

(a) The manager of medical records service shall ensure that medical records, whether original, computer media, or microfilm, be kept on file for a minimum of 11 years following the discharge of an adult patient.

(b) The manager of medical records shall ensure that if the patient is a minor, records shall be kept on file until his 19th birthday and, then, for 11 years.

(c) If a hospital discontinues operation, its management shall make known to the Division where its records are stored. Records are to be stored in a business offering retrieval services for at least 11 years after the closure date.

(d) Prior to destruction, public notice shall be made to permit former patients or their representatives to claim their own records. 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) The manager of medical records may authorize the microfilming of medical records. Microfilming may be done on or off the premises. If done off the premises, the facility shall take precautions to ensure the confidentiality and safekeeping of the records. The original of microfilmed medical records shall not be destroyed

until the medical records department has had an opportunity to review the processed film for content.

(f) 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 subsection are met and the information is readily available for use in patient care.

(g) All medical records are confidential. Only authorized personnel shall have access to the records. The written authorization of the patient shall be maintained in the original record as authority for release of medical information outside the facility.

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

*Statutory Authority G.S. 131E-79.*

### **.3904 PATIENT ACCESS**

The manager of medical records shall ensure that patients or patient designees, when requested, are given access to or a copy of their medical records, or both. Upon the death of a patient, the executor of the decedent's estate, or in the absence of an executor, the next of kin responsible for the disposition of the remains, shall have access to all medical records of the deceased patient. The patient or the patient's next of kin may be charged for the cost of reproducing copies in accordance with G.S. 90-411.

*Statutory Authority G.S. 131E-79.*

### **.3905 PATIENT MEDICAL RECORDS**

(a) Hospital management shall ensure that medical records are maintained for every patient treated or examined in the facility.

(b) The medical record or medical record system shall provide data for each episode of care and treatment rendered by the facility.

(c) Where the medical record does not combine all episodes of inpatient, outpatient and emergency care, the medical records system shall:

- (1) assemble, upon request of the physician, any or all divergently located components of the medical record when a patient is admitted to the facility or appears for outpatient or clinic services; or
- (2) require placing copies of pertinent



portions of each inpatient's medical record, such as the discharge resume, the operative note and the pathology report in the outpatient or combined outpatient emergency unit record file as directed by the medical staff.

(d) The manager of medical records shall ensure:

- (1) each patient's medical record is complete, readily accessible and available to the professional staff concerned with the care and treatment of the patient;
- (2) all significant clinical information pertaining to a patient is incorporated in his medical record;
- (3) all entries in the record are dated and authenticated by the person making the entry;
- (4) symbols and abbreviations are used only when they have been approved by the medical staff and when there exists a legend to explain them;
- (5) verbal orders include the date and signature of the person recording them. They shall be given and authenticated in accordance with the provisions of Rule .3707(e) of this Subchapter; and
- (6) records of patients discharged are completed within 30 days following discharge or disciplinary action is initiated as defined in the medical staff bylaws.

*Statutory Authority G.S. 131E-79.*

### **.3906 CONTENTS**

(a) The medical record shall contain sufficient information to justify the diagnosis, verify the treatment and document the course of treatment and results accurately.

(b) All in-patient records shall include the following information:

- (1) identification data (name, address, age, sex) and, when the identification data is not obtainable, the reason for such;
- (2) date and time of admission and discharge;
- (3) medical history;
  - (A) chief complaint;
  - (B) details of the present illness;
  - (C) relevant past, social, and family histories; and
  - (D) reports of relevant physical examinations;

- (4) diagnostic and therapeutic orders;
- (5) reports of procedures, tests and their results;
- (6) provisional or admitting diagnosis;
- (7) evidence of appropriate informed consent;
- (8) clinical observations, including results of therapy;
- (9) record of medication and treatment administration;
- (10) progress notes of all disciplines;
- (11) conclusions at termination of hospitalization or evaluation and treatment;
- (12) all relevant diagnosis established by the time of discharge;
- (13) consultation reports;
- (14) surgical record, including anesthesia record, pre-operative diagnosis, surgeon's operative report and post-operative orders and any instructions given to the patient or family; and
- (15) autopsy findings, if performed.

*Statutory Authority G.S. 131E-79.*

### **.3907 MEDICAL RECORDS REVIEW**

The medical staff shall review records periodically for completeness and shall:

- (1) establish requirements regarding completion of medical records, including a system for disciplinary actions for those who do not complete records in a timely manner; and
- (2) make recommendations to the medical records department to ensure that the recorded clinical information is sufficient for the purpose of medical care evaluation.

*Statutory Authority G.S. 131E-79.*

## **SECTION .4000 - OUTPATIENT SERVICES**

### **.4001 ORGANIZATION**

(a) Facility management shall assure that the type and scope of outpatient care services is established in accordance with the facility's written mission statement.

(b) The relationship of outpatient services to other divisions within the facility, including channels of responsibility and authority, shall be documented and made available for review by facility management.

(c) Facility management shall vest the direction of outpatient services in one or more individuals whose qualifications, authority and duties are defined in writing.

(d) The facility management shall ensure the review and evaluation of outpatient services.

(e) Each medical staff member shall have privileges delineated in accordance with criteria established by the medical staff by-laws.

*Statutory Authority G.S. 131E-79.*

#### **.4002 STAFFING**

(a) The director of outpatient services shall ensure that ambulatory care services are staffed with sufficient personnel in accordance with a written plan.

(b) The responsibility for the delivery of outpatient services by the professional staff shall be clearly defined and documented by the director of ambulatory care services.

(c) Facility management shall provide education programs specifically related to outpatient care for the staff and document the extent of participation in education and training programs.

*Statutory Authority G.S. 131E-79.*

#### **.4003 POLICIES AND PROCEDURES**

(a) The provision of outpatient services shall be guided by written policies and procedures which are current and approved by the medical staff. The policies and procedures shall be reviewed at least every three years.

(b) The policies shall include the following:

- (1) patient access to outpatient services;
- (2) the process of obtaining informed consent;
- (3) the location, storage and procurement of medications, supplies and equipment; and
- (4) the mechanism to be used to contact patients for necessary follow-up.

*Statutory Authority G.S. 131E-79.*

#### **.4004 OUTPATIENT SURGICAL AND ANESTHESIA SERVICES**

(a) When surgical or anesthesia services are provided in an outpatient setting, the facility shall ensure that the medical staff approve all types of surgical procedures to be offered. The facility shall maintain and make available a current listing of approved outpatient procedures.

(b) The facility shall define the scope of

anesthesia services that may be provided, the locations where such anesthesia services may be administered and who shall provide anesthesia services.

(c) The facility shall ensure that requirement for informed consent, history and physical examination, preoperative studies, administration of anesthesia, medical records and discharge criteria meet the same standards of care as apply for inpatient surgery unless otherwise specified by the medical staff.

(d) The facility shall ensure that provisions be made for back-up service by other departments in the case of emergencies or complications.

*Statutory Authority G.S. 131E-79.*

#### **.4005 MEDICAL RECORDS**

(a) The manager of outpatient services shall ensure that a record of outpatient care and service is developed for each patient and maintained either in the ambulatory care services or medical record department.

(b) Facility management shall ensure that a system of identification and filing as developed which will ensure safe storage and prompt retrieval upon subsequent inpatient or outpatient visits.

(c) Facility management shall ensure that medical records procedures include provisions for maintaining the confidentiality of patient information and for the release of information to authorized individuals.

*Statutory Authority G.S. 131E-79.*

### **SECTION .4100 - EMERGENCY SERVICES**

#### **.4101 EMERGENCY RESPONSE CAPABILITY REQUIRED**

The medical staff of each facility shall ensure that facility personnel are capable of initiating lifesaving measures at a first-aid level of response for any patient or person in need of such services. This shall include:

- (1) initiating basic cardio-respiratory resuscitation according to American Red Cross or American Heart Association standards;
- (2) availability of first-line emergency drugs as specified by the medical staff;
- (3) availability of IV fluids and supplies required to establish IV access; and
- (4) establishing protocols or agreements for the transfer of patients to a facility for



higher level of care when these services are not available on site.

*Statutory Authority G.S. 131E-79.*

#### **.4102 CLASSIFICATION OF OPTIONAL EMERGENCY SERVICES**

(a) Facility management of any facility providing emergency services shall classify its capability in providing such services according to the following criteria:

(1) Level I:

(A) the facility shall have a comprehensive, 24-hour-per-day emergency service with at least one physician experienced in emergency care on duty in the emergency care area;

(B) the facility shall have in-hospital physician coverage by members of the medical staff or by senior-level residents for at least medical, surgical, orthopedic, obstetric, gynecologic, pediatric and anesthesia services;

(C) services of other medical and surgical specialists shall be available; and

(D) the facility shall provide prompt access to labs, radiology, operating suites, critical care and obstetric units and other services as defined by the governing body.

(2) Level II:

(A) the facility shall have 24-hour per day emergency service with at least one physician experienced in emergency care on duty in the emergency care area; and

(B) the facility shall have consultation available within 30 minutes by members of the medical staff or by senior level residents to meet the needs of the patient. Consultation by phone is acceptable.

(3) Level III: The facility shall have emergency service available 24 hours per day with at least one physician available to the emergency care area within 30 minutes through a medical staff call roster.

(b) Facilities seeking trauma center designation shall comply with G.S. 131E-162.

(c) The location of the emergency access area shall be identified by clearly visible signs.

*Statutory Authority G.S. 131E-79.*

#### **.4103 PROVISION OF EMERGENCY SERVICES**

(a) Facility management of any facility providing emergency services shall ensure that medical screening, treatment and transfer services for any individual who presents to the facility emergency department and on whose behalf a request for treatment is made shall be provided regardless of that person's ability to pay for medical services.

(b) Facility management shall ensure that the facility shall not delay provision of the medical screening examination or treatment required in order to inquire about the individual's method of payment status.

(c) Any facility providing emergency services under this section shall install, 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 voice radio communication with ambulance units transporting patients to said facility or having any written procedure or agreement for handling emergency services with the local ambulance service, rescue squad or other trained medical personnel.

(d) All communication equipment shall be in compliance with current rules established by North Carolina Rules for Basic Life Support/Ambulance Service (10 NCAC 3 .1100) adopted by reference with all subsequent amendments. Referenced rules are available at no charge from the Office of Emergency Medical Service, P.O. Box 29530, Raleigh, N.C. 27626-0530.

*Statutory Authority G.S. 131E-79.*

#### **.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 or holidays.

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

(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.

*Statutory Authority G.S. 131E-79.*

#### **.4105 NURSING**

(a) Level I and Level II emergency services shall have one or more registered nurses assigned and on duty within the emergency service area at all times.

(b) A Level III emergency service shall have a registered nurse available on at least an on-call, in-house basis at all times.

(c) All emergency services nursing personnel shall have documented orientation, training and continuing education in the reception and care of emergency patients.

*Statutory Authority G.S. 131E-79.*

#### **.4106 POLICIES AND PROCEDURES**

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

- (1) the location, storage, and procurement of medications, blood, supplies, equipment and the procedures to be followed in the event of equipment failure;
- (2) the initial management of patients with burns, hand injuries, head injuries, fractures, multiple injuries, poisoning, animal bites, gunshot or stab wounds 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 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 and federal laws.

*Statutory Authority G.S. 131E-79.*

#### **.4107 EMERGENCY RECORDS**

(a) Facility management shall ensure all levels of emergency departments maintain a continuous control register on each patient seen for services which shall include at least the name, age, sex, date, time, and means of arrival, nature of complaint, disposition, and time of discharge.

(b) Facility management shall ensure that a record shall be maintained for each patient seeking emergency care. This shall include:

- (1) patient identification, time and means of arrival;
- (2) pertinent history and physical findings and patient vital signs;
- (3) diagnostic and therapeutic orders;
- (4) clinical observations including results of treatment;
- (5) reports of procedures, tests and results;
- (6) diagnostic impression; and
- (7) discharge or transfer summary of treatment including final disposition, the patient's condition, and any instructions given to the patient and or family for follow-up care.

*Statutory Authority G.S. 131E-79.*

#### **.4108 OBSERVATION BEDS**

When observation beds are used, facility management shall ensure that there shall be written policies and procedures that address the type of patient use, the mechanism for providing appropriate clinical monitoring, the length of time services may be provided in this setting and documentation requirements.

*Statutory Authority G.S. 131E-79.*

#### **.4109 TRANSFER**

(a) Facility management shall ensure that the facility has established protocols for stabilization and transportation of emergency patients.

(b) A facility with specialized capabilities, such as burn units, shock-trauma units and neonatal intensive care units, shall not refuse to accept an appropriate transfer for those services if the hospital has the capacity to treat the individual.

(c) Hospital management shall ensure that a patient shall not be transferred until the receiving organization has consented to accept the patient and the patient is sufficiently stable for transport.

(d) If the patient or the person acting on the patient's behalf refuses transfer, the facility staff



SECTION .4200 - SPECIAL  
CARE UNITS

shall:

- (1) explain to the individual or his representative the risks and benefits of transfer; and
- (2) shall request the patient's or his representative's refusal of transfer in writing.
- (e) Facility management shall ensure that a copy of all medical records related to the emergency condition for which the individual has presented shall be made available at the time of the transfer, and shall accompany the patient to the receiving facility.

Statutory Authority G.S. 131E-79.

.4110 DISASTER AND MASS  
CASUALTY PROGRAM

- (a) Facility management shall describe:
  - (1) the level of emergency services available during an external disaster;
  - (2) the emergency department's place in the facility's external disaster plan;
  - (3) procedures to be followed in the event of an internal disaster; and
  - (4) the facility's connection to other community services such as fire, police and the American Red Cross.
- (b) The medical staff and governing body shall approve the plan, review it and revise it if needed, annually.
- (c) The plan shall:
  - (1) provide for prompt medical attention for all emergency patients as their needs may dictate;
  - (2) include protocols for handling non-emergency cases;
  - (3) establish medical staff coverage procedures or methods;
  - (4) specify drugs, solutions and equipment to be continuously available;
  - (5) provide for the evacuation and transfer for all inpatients as there needs may indicate in the event of an internal disaster; and
  - (6) include mutual support agreements with area providers.
- (d) Schedules, names and telephone numbers of all physicians and others on emergency duty shall be maintained by the facility.
- (e) Names and telephone numbers of those to be contacted in the event of an internal disaster shall be maintained by the facility.

Statutory Authority G.S. 131E-79.

.4201 ORGANIZATION

- (a) The governing body shall approve the type and scope of special care units.
- (b) Facility management shall assure that the relationship of the special care units to the other departments within the hospital, including channels of responsibility and authority, be documented and available for review.
- (c) Facility management shall ensure that there are necessary equipment and supplies for delivery of nursing care specific to the unit population for each special care unit.
- (d) Facility management shall ensure that the facility has sufficient emergency drugs and equipment to meet anticipated needs as determined by the medical staff.
- (e) The governing body shall delegate to the medical and nursing staff the responsibility to develop policies and procedures concerning the scope and provision of safe care in each unit.

Statutory Authority G.S. 131E-79.

.4202 MEDICAL STAFF

- (a) The governing body shall ensure that each special care unit or group of similar units be directed by qualified members of the medical staff whose clinical and administrative privileges have been approved by the governing board.
- (b) The governing body shall designate the director to be responsible for making decisions in consultation with the physician responsible for the patient, for the disposition of a patient when patient load exceeds optimal operation capacity.
- (c) The governing body shall ensure that the medical staff provide medical staff coverage sufficient to meet the specific needs of the patients on a 24-hour basis.

Statutory Authority G.S. 131E-79.

.4203 NURSING STAFF

- Facility management shall ensure the supervision of nursing care for each special care unit be provided by a qualified registered nurse. The supervisor shall ensure the following:
- (1) unit-specific orientation and competency evaluation for each staff member;
  - (2) a staffing plan based upon the needs of the patient population which is implemented to ensure a sufficient number of qualified Registered Nurses are on duty

- when patients are in the unit;
- (3) assessment, planning, implementation and evaluation of nursing care which is documented according to policy; and
  - (4) delivery of nursing care in accordance with the North Carolina Nurse Practice Act.

Statutory Authority G.S. 131E-79.

#### .4204 POLICIES AND PROCEDURES

(a) Facility management shall assure that written policies and procedures which guide the provision of care be developed by the medical and nursing staff. Facility management shall ensure that policies and procedures are approved by the medical staff and that they include:

- (1) patient admission and discharge criteria;
- (2) notification of appropriate medical staff for changes in the condition of the patient;
- (3) use of standing orders and emergency protocols;
- (4) designation of staff members authorized to perform special procedures and special circumstances requiring such authorization;
- (5) patient care procedures, including medication administration;
- (6) infection control;
- (7) pertinent safety practices;
- (8) use of equipment and procedures to be followed in the even of equipment failure;
- (9) regulations governing visitors and traffic control; and
- (10) role of special care unit in internal and external disaster plans.

(b) The governing body shall review, update and approve regularly, but at least every three years, its policies and procedures.

Statutory Authority G.S. 131E-79.

### SECTION .4300 - MATERNAL - NEONATAL SERVICES

#### .4301 ORGANIZATION MATERNAL SERVICES

(a) The governing body shall approve the scope of obstetric services offered based upon the level of patient need, qualifications of the credentialed staff, and resources of the facility.

(b) The following capabilities and minimum services shall be made available when obstetric

services are provided:

- (1) identification of high-risk mothers and fetuses;
- (2) continuous electronic fetal monitoring;
- (3) cesarean delivery capability within 30 minutes of decision;
- (4) blood or fresh frozen plasma for transfusion;
- (5) anesthesia on a 24-hour or on-call basis;
- (6) radiology and ultrasound examination;
- (7) stabilization of unexpectedly small or sick neonates before transfer;
- (8) neonatal resuscitation;
- (9) laboratory services on a 24-hour or on-call basis;
- (10) consultation and transfer agreements;
- (11) assessment and care for the neonates; and
- (12) nursery or other appropriate space for care of the neonates.

(c) In a facility without intensive care nursery services, the facility management shall establish procedures for the stabilization and transportation of sick newborns to a regional neonatal unit and maintain the essential equipment necessary for transport.

Statutory Authority G.S. 131E-79.

#### .4302 MEDICAL DIRECTOR MATERNAL SERVICES

(a) The medical staff shall ensure that each birth is attended by a physician or certified nurse midwife who has documented evidence of current competence and appropriate privileges.

(b) Medical staff with obstetrical privileges shall be available in the facility to provide services within 30 minutes at all times to attend deliveries. An on-call schedule shall be available to the Division for review.

Statutory Authority G.S. 131E-79.

#### .4303 NURSING SERVICES MATERNAL SERVICES

(a) The nurse executive or the decentralized nursing management staff shall designate a registered nurse who has education, training, and experience in obstetrical care as supervisor of obstetrical services.

(b) A registered nurse shall be assigned responsibility for providing the type and amount of nursing care needed by each patient. A staffing plan shall be available to the Division for review.



Statutory Authority G.S. 131E-79.

**.4304 POLICIES AND PROCEDURES  
MATERNAL SERVICES**

(a) The provision of patient care shall be guided by written policies and procedures developed by the medical and nursing staff and approved by the medical staff.

(b) Written policies shall relate to at least the following:

(1) a system for informing the physician responsible for a patient of the following:

(A) the patient's admission;

(B) the onset of labor; and

(C) pertinent information about progress of labor or changes in patient's condition.

(2) emergency response protocols for patients who demonstrate evidence of maternal, fetal or neonatal distress;

(3) a program to prevent isoimmunization of RH-negative mothers;

(4) administration of oxytocic agents when used for induction or stimulation of labor;

(5) the use and administration of analgesics and anesthetics;

(6) administration of magnesium sulfate when and for the treatment preeclampsia;

(7) explicit directions as to the location and storage of medications, supplies, and special equipment;

(8) the method of identification for the neonates;

(9) assessment and care of the neonates;

(10) provision of resuscitation, stabilization, and preparation for the transport of sick newborns at any hour; and

(11) an infection control plan.

(c) Accurate and complete medical records shall be provided for each obstetric patient.

Statutory Authority G.S. 131E-79.

**.4305 ORGANIZATION OF NEONATAL  
SERVICES**

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

(1) LEVEL I or Neonate Nursery: neonates that are stable without

complications; may include premature, small for gestational age or large for gestational age neonates;

(2) LEVEL II: Ill neonates or infants requiring less constant nursing care but does not exclude respiratory support; may serve as "step-down" unit from LEVEL III; and

(3) LEVEL III: Medically unstable or critically ill neonates requiring constant nursing care or supervision involving complicated surgical procedures, continual respiratory or other intensive interventions.

(b) Facility management shall ensure 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.

Statutory Authority G.S. 131E-79.

**.4306 MEDICAL STAFF OF NEONATAL  
SERVICES**

The medical staff shall ensure the director or other designated physician in charge of the neonatal special or intensive care unit has training and experience in care of the neonate.

Statutory Authority G.S. 131E-79.

**.4307 NURSING STAFF OF NEONATAL  
SERVICES**

(a) The nurse executive or the decentralized nursing management staff shall designate a registered nurse who has training and experience in the care of neonates as supervisor of neonatal services.

(b) A registered nurse shall be assigned responsibility for providing the type and amount of nursing care needed by each patient. A staffing plan shall be available to the Division for review.

(c) The nursing staff shall provide educational opportunities for parents of neonates on routine care and procedures needed by the neonate.

(d) The nursing staff shall provide opportunities for parental participation in care of the neonate to facilitate bonding and family adjustment to the neonate's needs.

Statutory Authority G.S. 131E-79.

**.4308 POLICIES AND PROCEDURES OF  
NEONATAL SERVICES**

(a) The provision of neonatal care at all levels shall be guided by written policies and procedures.

(b) The policies and procedures shall include but are not limited to:

- (1) emergency resuscitation and stabilization of the neonate;
- (2) equipment for routine and emergency care of the neonate;
- (3) continuous oxygen supply and means of administration including ventilators;
- (4) administration of medications;
- (5) insertion and care of invasive lines;
- (6) prevention of infectious diseases or processes transmission; and
- (7) family involvement in care of the neonate.

(c) The medical and nursing staff shall review, update and approve regularly, but at least every three years its policies and procedures.

*Statutory Authority G.S. 131E-79.*

## SECTION .4400 - RESPIRATORY CARE SERVICES

### .4401 ORGANIZATION

(a) The governing body shall appoint a medical director of the respiratory care service who is an anesthesiologist, pulmonologist or other qualified physician.

(b) Facility management shall appoint a qualified individual as the director of respiratory care services.

(c) The director of the service shall designate a qualified person to supervise the respiratory care staff.

(d) When the facility is without a distinct respiratory care service, facility management shall:

- (1) designate the department responsible for the delivery of respiratory care services;
- (2) designate a person to supervise the delivery of respiratory care services; and
- (3) establish policies and procedures for the delivery of respiratory care services offered.

*Statutory Authority G.S. 131E-79.*

### .4402 STAFFING

(a) Staffing numbers shall be determined by the types and complexities of the services offered.

(b) The director of the service shall ensure the availability of trained respiratory technicians,

Certified Respiratory Therapy Technicians, registry eligible or Registered Respiratory Therapist needed for the scope of services offered.

*Statutory Authority G.S. 131E-79.*

### .4403 POLICIES AND PROCEDURES

Facility management shall establish written policies and procedures for the services offered. These shall include but are not limited to:

- (1) scope of services and treatment offered;
- (2) medication administration;
- (3) cleaning, assembly and storage of equipment;
- (4) safety;
- (5) infection control;
- (6) documentation of delivered care or treatments; and
- (7) care and supervision of all ventilated patients.

*Statutory Authority G.S. 131E-79.*

## SECTION .4500 - PHARMACY SERVICES AND MEDICATION ADMINISTRATION

### .4501 PROVISION OF SERVICE

The facility shall provide for pharmaceutical services which are administered in accordance with the pharmacy laws of North Carolina including but not limited to G.S. 90 and G.S. 106.

*Statutory Authority G.S. 131E-79.*

### .4502 PHARMACIST

(a) The pharmacy service shall be directed by a pharmacist licensed by the State of North Carolina. If a facility has a limited service as defined by the N.C. Board of Pharmacy, a part-time director of pharmacy shall have responsibility for control and dispensing of drugs.

(b) The director of pharmacy shall be responsible to the chief executive officer or his designee for developing, supervising, and coordinating all the activities of pharmacy services throughout the facility.

(c) The director of pharmacy shall ensure that the pharmacists are trained in the specialized functions of facility pharmacy.

(d) The dispensing of drugs in the absence of a pharmacist shall be members who are under the direct supervision of staff approved by the pharmacy committee and who are responsible for following policies established by the pharmacy



committee.

*Statutory Authority G.S. 131E-79.*

#### **.4503 STAFF**

The director of pharmacy shall be assisted by additional pharmacists and such other personnel as the activities of the pharmacy may require to meet the pharmaceutical needs of the patients served.

*Statutory Authority G.S. 131E-79.*

#### **.4504 PHARMACY COMMITTEE**

(a) A pharmacy committee or its equivalent, to include physicians, nurses, pharmacists and the administrator or designee shall be established.

(b) The committee shall meet at least quarterly, record its proceedings and report to the medical staff. It shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use and safety procedures, and all other matters relating to drugs in the facility. This should include a mechanism to review and evaluate adverse drug reactions and drug usage evaluations, offering appropriate recommendations, actions, and follow-up if necessary. The committee shall:

- (1) serve as an advisory group to the medical staff and the pharmacy director on matters pertaining to drug selection;
- (2) develop an ongoing mechanism to review a formulary or drug list for use in the hospital;
- (3) recommend and develop policies regarding the use and control of investigational drugs and research in the use of U.S. Food and Drug Administration approved drugs;
- (4) evaluate clinical data concerning new drugs or preparations requested for use in the facility;
- (5) make recommendations concerning drugs to be stocked on the nursing units and by other services;
- (6) establish mechanisms which will prevent formulary duplication;
- (7) establish policies and procedures that address therapeutic drug substitution;
- (8) establish a policy to ensure that the duration of drug therapy or number of doses is established for all medication orders; and
- (9) make recommendations regarding medication administration policies and procedures.

*Statutory Authority G.S. 131E-79.*

#### **.4505 PHARMACY FACILITIES**

Facility management shall provide equipment and supplies for the pharmaceutical service to carry out its professional and administrative functions and to ensure patient safety through the proper storage and dispensing of drugs. Space and equipment shall be provided for the storage, safeguarding, preparation and dispensing of drugs.

*Statutory Authority G.S. 131E-79.*

#### **.4506 SUPPLIES**

The director of pharmacy shall ensure that a supply of drugs and pharmaceutical devices adequate to meet the needs of the patients and the medical staff is maintained.

*Statutory Authority G.S. 131E-79.*

#### **.4507 STORAGE**

(a) All drugs and related pharmaceutical supplies located throughout the facility shall be under the control of the pharmacy service.

(b) All areas where drugs and related pharmaceutical supplies are stored shall be monitored at least monthly by the pharmacy service.

(c) The director of pharmacy shall ensure that corresponding records are maintained of drug inventory variances and the corrective action taken.

*Statutory Authority G.S. 131E-79.*

#### **.4508 SPACE**

Adequate space shall be provided for all pharmacy operations and drugs shall be stored in a satisfactory location provided with proper lighting, ventilation and temperature controls, as specified by the U. S. Food & Drug Administration, Dockets Management Branch, FDS, Room 4-62, 5600 Fishers Lane, Rockville, Maryland 20857; at a cost dependent on the material requested and the U.S. Pharmacopoeia, US Pharmacopoeia, 12601 Twinbrook Parkway, Rockville, Maryland 20852 (1-800-227-8772), at a cost of four hundred fifty dollars (\$450.00) plus twelve dollars (\$12.00) shipping and handling.

*Statutory Authority G.S. 131E-79.*

#### **.4509 SECURITY**

(a) The director of pharmacy shall ensure that

all drugs and related pharmaceutical supplies be stored in a lockable environment except when under the direct supervision of personnel authorized by the pharmacy committee to handle drugs.

(b) Controlled substances and other drugs the facility deems subject to abuse shall be stored as outlined in the U.S. Controlled Substance Act, CFR 1301.41 and the N.C. Controlled Substances Act, G.S. 90, Article 5. These rules are available from the Regulatory Section of the N.C. Division of Mental Health, Development Disabilities & Substance Abuse Services, 325 N. Salisbury St., Raleigh, N.C. 27603 (919/715-0652) without charge to current registrants.

(c) All keys and other locking devices to the pharmacy and controlled substances throughout the facility shall be under the control of the director of pharmacy and the hospital management.

*Statutory Authority G.S. 131E-79.*

#### **.4510 RECORDS**

(a) The director of pharmacy shall ensure that all drug transactions of the pharmacy shall be recorded as described in policies approved by the pharmacy committee.

(b) The director of pharmacy shall establish and maintain a system of records and bookkeeping in accordance with the policies of the facility in order to maintain adequate control over the requisitioning and dispensing of all drugs and pharmaceutical supplies and over patient billing for all drugs and pharmaceutical supplies.

(c) The director of pharmacy shall ensure that records for drugs dispensed from the pharmacy shall be maintained in the pharmacy. Records of drugs administered to patients shall be maintained in the medical record of the patient.

(d) Verbal orders for drugs shall be subject to medical staff policies.

*Statutory Authority G.S. 131E-79.*

#### **.4511 MEDICATION ADMINISTRATION**

(a) A facility shall have policies and procedures governing the administration of medications which shall be enforced and implemented by administration and staff. Policies and procedures shall include, but shall not necessarily be limited to:

- (1) accountability of controlled substances as defined by the G.S. 90, Article 5; and
- (2) dispensing and administering behavior

modifying drugs, and psychotherapeutic agents; insulin; intravenous fluids and medications; cardiovascular drugs; antibiotics; and cytotoxic and related agents.

(b) Nursing staff are responsible for ensuring that all medications or drugs and treatments are administered and discontinued in accordance with signed physician's orders which are recorded in the patient's medical record.

(c) The governing body shall ensure that the facility's bylaws and operational policies clearly describe the categories of staff that are privileged to administer medications. These policies shall be in agreement with current rules of North Carolina Occupational Boards for each category of staff.

(d) Medications shall be scheduled and administered according to the established policies of the facility.

(e) Variances to the medication administration policy shall be reviewed and evaluated by the nurse executive or her designee.

(f) The person administering medications shall identify each patient in accordance with the facility's policies and procedures prior to administering any medication.

(g) Medication administered to a patient shall be recorded in the patient's medication administration record immediately after administration in accordance with the facility's policies and procedures.

(h) Omission of medication and the reason for the omission shall be indicated in the patient's medical record.

(i) The person administering medications which are ordered to be given as needed (PRN) shall justify the need for the same in the patient's medical record.

(j) Medication administration records shall provide identification of the drug and strength of drug, quantity of drug administered, route administered, name and title of person administering the medication, and time and date of administration.

(k) Self-administration of medications shall be permitted only if prescribed by the medical staff. Directions must be printed on the container.

(l) The administration of one patient's medications to another patient is prohibited except in the case of an emergency. In the event of such as emergency, steps shall be taken by a pharmacist to ensure that the borrowed medications shall be replaced and so documented.

(m) Verbal orders shall be countersigned in accordance with Rule .3707(e) of this Subchapter.



*Statutory Authority G.S. 131E-79.*

#### **.4512 MEDICATIONS DISPENSED**

(a) The pharmacy shall dispense only those drugs which are listed in one or more of the references listed in Paragraph (b) of this Rule or as provided in Paragraph (c) of this Rule. Any drug unfavorably evaluated in any of these references shall be used only in accordance with standards established by the facility's pharmacy committee.

(b) References:

- (1) United States Pharmacopoeia;
- (2) National Drug Formulary;
- (3) Evaluations of Drug Interactions by the American Pharmaceutical Association;
- (4) American Hospital Formulary Service; and
- (5) Other references approved by the Pharmacy Committee.

(c) Any drug approved for use as an investigational drug or otherwise by the U.S. Food and Drug Administration but not listed in Paragraph (b) of this Rule may be used in accordance with standards established by the facility's pharmacy committee, or its equivalent and approved by the U.S. Food and Drug Administration, Dockets Management Branch, FDS, Room 4062, 5600 Fishers Lane, Rockfield, Maryland 20857, at a cost dependent on the material requested.

*Statutory Authority G.S. 131E-79.*

#### **.4513 DRUG DISTRIBUTION SYSTEMS**

(a) The pharmacy committee shall develop written policies and procedures pertaining to the intra-facility drug distribution system. In developing such policies the committee shall utilize representatives of other disciplines within the facility, including nursing services.

(b) The label of each patient's individual medication container shall bear all information required by the Pharmacy Laws of North Carolina.

(c) The pharmacist, with the advice and guidance of the pharmacy committee or its equivalent, shall be responsible for specifications as to quality, quantity and source of supplies of all drugs.

(d) There shall be a formulary or list of drugs accepted for use in the facility which shall be developed and amended as necessary by the pharmacy committee.

*Statutory Authority G.S. 131E-79.*

#### **.4514 EMERGENCY PHARMACEUTICAL SERVICES**

Provision shall be made for emergency pharmaceutical services as currently described in the Pharmacy Laws of North Carolina.

*Statutory Authority G.S. 131E-79.*

#### **.4515 DISPOSITION**

The director of pharmacy shall ensure that drugs, and pharmaceutical devices throughout the facility which are outdated, visibly deteriorated, unlabeled, inadequately labeled, recalled, discontinued or obsolete shall be identified by a pharmacist and shall be disposed of in compliance with applicable state and federal laws and regulations.

*Statutory Authority G.S. 131E-79.*

#### **.4516 COMMERCIAL PHARMACEUTICAL SERVICE**

A facility using an outside pharmacist or pharmaceutical service must have a contract with that pharmacist or service. As part of the contract, the pharmacist or service shall be required to maintain at least the standards for operation of the pharmaceutical services outlined in this Subchapter.

*Statutory Authority G.S. 131E-79.*

### **SECTION .4600 - SURGICAL AND ANESTHESIA SERVICES**

#### **.4601 ORGANIZATION**

(a) The governing body shall approve the types of surgery and types of anesthesia services to be available throughout the hospital consistent with identified needs and resources.

(b) Facility management shall assure that surgical or anesthesia procedures are performed only when the necessary equipment and personnel are available.

(c) A facility that provides surgical or obstetric services shall provide anesthesia services on a 24-hour basis.

(d) Facility management shall ensure that requirements and standards identified in this section apply when any patient, in any setting, receives for any purpose, by any route:

- (1) general, spinal or other major regional anesthesia; or
- (2) sedation or analgesia that may result in the loss of protective reflexes; or
- (3) surgery or other invasive procedure

while receiving such anesthesia.

*Statutory Authority G.S. 131E-79.*

#### **.4602 DIRECTOR OF SURGICAL SERVICES**

(a) Facility management shall assure that each department or service providing surgical services be directed by members of the medical staff whose clinical and administrative privileges have been approved by the governing body.

(b) The medical staff shall ensure a system for monitoring and evaluating the quality and appropriateness of the care and treatment of surgical patients, and for monitoring the clinical performance of all individuals with clinical privileges.

(c) In facilities where there is no anesthesiologist on staff the facility management shall:

- (1) with review of the medical staff, establish a consultation agreement with a board-certified or board-eligible anesthesiologist for the purpose of establishing policies and procedures for anesthesia safety and policies that relate to the administration of anesthesia in all departments or services of the facility;
- (2) assume the responsibility for establishing general policies for anesthesia services; and
- (3) establish a line of communication and supervision for staff.

*Statutory Authority G.S. 131E-79.*

#### **.4603 SURGICAL AND ANESTHESIA STAFF**

(a) Facility management shall develop processes to ensure that each individual provides only those services for which proof of licensure and competency can be demonstrated.

(b) Facility management shall ensure:

- (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 anesthesiologists, 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.

*Statutory Authority G.S. 131E-79.*

#### **.4604 DIRECTION OF ANESTHESIA SERVICES**

(a) Facility management shall ensure that anesthesia care be organized, directed and integrated with other related services or departments of the facility.

(b) The department of anesthesia shall be responsible for ensuring that all anesthetics are administered as established in the medical staff rules. In facilities where there is no department of anesthesia, the medical staff shall assume the responsibility for establishing general policies and for supervising the administration of anesthetics.

(c) Facility management shall ensure that anesthesia services be directed by a member, or members, of the medical staff whose responsibilities shall be approved by the governing body and shall include:

- (1) establishment of criteria and procedures for the evaluation of the quality of all anesthesia care rendered;
- (2) review of clinical privileges for all licensed practitioners whose primary clinical activity is the provision of anesthesia services; and
- (3) establishment of written policies and procedures for anesthesia services.

*Statutory Authority G.S. 131E-79.*

#### **.4605 POLICIES AND PROCEDURES**

(a) The director of surgical services shall develop policies and procedures for surgical and anesthesia services which shall be available to the medical, surgical, anesthesia staff and nursing personnel.

(b) Facility management shall ensure that policies on anesthesia procedures include the delineation of pre-anesthesia and post-anesthesia responsibilities.



(c) Facility management shall ensure that the policies listed below are followed for each patient:

- (1) a complete history and physical documented in the chart of every patient prior to surgery, including clinical indications for the surgical procedure;
- (2) an informed consent, in the patient's chart before surgery;
- (3) an evaluation of the patient and anesthesia planned, documented according to medical staff bylaws by an individual qualified to administer anesthesia services. Re-evaluation of the patient immediately prior to the induction of anesthesia shall be performed prior to surgery;
- (4) an operative report describing techniques, findings, tissue removed or altered, and pre and post-surgical diagnosis. This report must be written or dictated following surgery and signed by the surgeon in compliance with medical staff rules;
- (5) an intraoperative anesthesia record including the dosage of all drugs and agents used, the duration of anesthesia, and the type and amount of all fluids or blood and blood products administered shall be documented;
- (6) evaluation and documentation of the postoperative status of the patient on admission to and discharge from the post-anesthesia recovery area; and
- (7) procedure to follow in the event that informed consent cannot be obtained.

(d) The director of anesthesia services shall establish and apply criteria for discharge to determine the readiness of the patient for discharge.

- (1) The facility shall ensure that a physician or CRNA with appropriate clinical privileges be responsible for the decision to discharge a patient from a post-anesthesia recovery area;
- (2) With respect to outpatients, the hospital shall insure that a post-anesthesia evaluation be performed in accordance with policies and procedures approved by the medical staff.

(e) Facility management shall establish regulations governing visitors and traffic control.

*Statutory Authority G.S. 131E-79.*

## SECTION .4700 - NUTRITION AND DIETETIC SERVICES

### .4701 PROVISION OF SERVICES

The nutrition and dietetic services shall be organized, directed, staffed and integrated with other facility departments to provide optimal nutritional therapy and quality food service to patients. Nutrition therapy shall apply the principles of the science of nutrition and be administered in accordance with the law and rules including but not limited to G.S. 90, Article 25.

*Statutory Authority G.S. 131E-79.*

### .4702 ORGANIZATION

(a) The nutrition and dietetic services shall be under the full-time direction of a person who is trained or experienced in food services administration and therapeutic diets. The director shall be one of the following:

- (1) A qualified dietitian;
- (2) An individual who possesses at least the following minimum qualifications:
  - (A) Bachelor's degree in Foods and Nutrition or Food Service Management;
  - (B) Dietetic Technician Registered (DTR); or
  - (C) Certified Dietary Manager (CDM); or
- (3) An individual who is enrolled in a program to complete the minimum qualifications in Paragraph (a)(1)(2)(A)(B)(C) of this Rule.

(b) The nutrition and dietetic services of the facility shall have at least one dietitian either full-time, part-time, or as consultant. The qualifications of the dietitian shall be included in the personnel files. If the director of nutrition and dietetic services is not a registered dietitian, there shall be an established method of communication between the director and the dietitian which ensures that the dietitian supervises the nutritional aspects of patient care and ensures that quality nutritional care is provided to patients. Dietitians or qualified designees shall attend and participate in meetings relevant to patient nutritional care, including but not limited to patient care conferences and discharge planning.

(c) When a dietitian serves only in a consultant capacity, the facility management shall have a written contract with the individual which shall clearly define the responsibilities which includes the submission of written reports to the hospital administrator and the director of the nutrition and

dietetic services describing the extent and quality of the services provided. Frequency of visits of the consultant dietitian shall be defined in the contract. The consultant dietitian shall provide, on site, no less than eight hours of service every two weeks to provide the nutritional aspects of patient care including but not limited to the following:

- (1) approval of regular and modified menus, including standardized recipes;
- (2) performance of nutritional assessments;
- (3) development of nutrition care plans;
- (4) provision of nutrition therapy;
- (5) participation in development of policies and procedures; and
- (6) monitoring and evaluation of the effectiveness and appropriateness of nutrition and dietetic services.

(d) Facility management shall ensure that there are written policies and procedures to govern all nutrition and dietetic service activities. These policies shall be developed by the nutrition and dietetic services in cooperation with personnel from other departments or services which are involved with nutrition and dietetic services and they shall be reviewed at least every three years, revised as necessary, and dated to indicate the time of last review. Administrative policies and procedures concerning food procurement, preparation, and service shall be written by the director of the nutrition and dietetic services. Nutritional care policies and procedures shall be written by the qualified dietitian. The nutrition and dietetic service policies and procedures shall include, but not be limited to the following:

- (1) provision of food and nutrition therapy prescriptions/orders;
- (2) development, approval and provision of regular and modified menus, including standardized recipes;
- (3) food purchasing, storage, inventory, preparation and service;
- (4) identification system designed to ensure that each patient receives appropriate diet as ordered;
- (5) ancillary dietetic services, as appropriate, including food storage and kitchens on patient care units, formula supply, cafeterias, vending operations and ice making;
- (6) preparation, storage, distribution, and administration of enteral nutrition programs;
- (7) assessment and monitoring of patients receiving enteral and total parenteral nutrition;

- (8) personal hygiene and health of dietetic personnel;
- (9) infection control measures to minimize the possibility of contamination and transfer of infection, including establishment of monitoring procedure to ensure that personnel are free from communicable infections and open skin lesions; and
- (10) pertinent safety practices, including control of electrical, flammable, mechanical, and radiation hazards.

(e) Nutrition and dietetic services shall be provided by qualified personnel under supervision to meet needs of patients. The director of the nutrition and dietetic services shall ensure that personnel assigned to the department perform all functions necessary to meet the nutritional needs of patients. The director or qualified designee shall attend and participate in meetings, including that of department heads, and function as an integral member of the facility.

(f) A facility which has a contract with an outside food management service, shall require as a part of the contract that the company complies with all applicable requirements and standards outlined in Section .4700 of this Subchapter for such service. The contract shall be available for review by the Division.

*Statutory Authority G.S. 131E-79.*

#### **.4703 SANITATION AND SAFETY**

(a) The nutrition and dietetic service shall maintain a Grade A sanitation rating and comply with current laws and rules for sanitation as promulgated by the Commission for Health Services. The facilities and equipment of the nutrition and dietetic services shall be in compliance with applicable sanitation and safety laws and rules. 15A NCAC 18A .1300 incorporated by reference including subsequent amendments and additions. Copies of 15A NCAC 18A .1300 may be obtained at no charge from the Environmental Health Section, Health Division, N.C. Department of Environment, Health and Natural Resources, P.O. Box 27687, Raleigh, NC 27611-7687.

(b) Sufficient space and equipment shall be provided for the nutrition and dietetic services to accomplish the following:

- (1) store food and nonfood supplies under sanitary and secure conditions;
- (2) store food separately from nonfood supplies. When storage facilities are



limited, paper products may be stored with food supplies;

- (3) prepare and distribute food, including therapeutic diets;
- (4) clean and sanitize utensils and dishes apart from food preparation areas; and
- (5) allow personnel to perform their duties.

(c) Cleaning schedules and instructions for cleaning all equipment and work and storage areas shall be posted and followed in the nutrition and dietetic services area and accessible to all nutrition and dietetics staff. Procedures for cleaning all equipment and work areas shall be followed consistently and documented to safeguard the health of the patient.

*Statutory Authority G.S. 131E-79.*

#### **.4704 DISTRIBUTION OF FOOD**

Foods being displayed or transported shall be protected from contamination and spoilage in clean containers, and cabinets, or serving carts. The food temperatures at the serving time shall be within the following acceptable ranges:

- (1) Hot liquids - 150 degrees (minimum);
- (2) Hot Cereal - 150 degrees (minimum);
- (3) Soups - 130 degrees (minimum);
- (4) Hot foods - 110 degrees (minimum);
- (5) Cold liquids - 50 degrees (maximum);
- (6) Cold foods - 65 degrees (maximum).

*Statutory Authority G.S. 131E-79.*

#### **.4705 NUTRITIONAL SUPPORT**

(a) The administration of the nutritional support shall be directed by a qualified dietitian. Observations and information pertinent to nutrition therapy shall be documented in the medical record of the patient.

(b) The facility shall have a current nutrition care manual accessible to hospital personnel. The nutrition care manual shall be reviewed every three years, revised as necessary by a qualified dietitian, and approved jointly by the nutrition service and medical staff.

(c) Therapeutic diets and enteral and parenteral nutrition therapy shall be prescribed in written orders on the medical records and provided as ordered.

(d) The nutrition care manual shall reflect the standards for nutrition care that are at least in accordance with those referenced in the most current edition of "Recommended Dietary Allowance" of the Food and Nutrition Board of the National Research Council of the National

Academy of Sciences. These standards include any subsequent amendments and editions of the referenced material and are available from the Office of Publications, National Academy Press, 2101 Constitution Avenue, N.W., Washington, D.C. 20418 at a cost of six dollars (\$6.00) per copy. The nutrition deficiencies of any modified diet that is not in compliance with the recommended dietary allowances shall be specified in the nutrition care manual.

(e) The qualified dietitian shall be responsible for the development of a nutritional care plan in compliance with physician's orders to meet the nutritional needs of the patient. The nutrition care plan shall be included in the medical record of the patient on his discharge plan and transfer orders to the extent necessary for continuity of care. Facilities with long term care units shall have at least a three week menu cycle in the long term care units.

*Statutory Authority G.S. 131E-79.*

### **SECTION .4800 - DIAGNOSTIC IMAGING**

#### **.4801 ORGANIZATION**

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

(b) Activities of the imaging service may include radio-therapy.

(c) All imaging equipment shall be operated under professional supervision by qualified personnel trained in the use of imaging equipment and knowledgeable of safety precautions required by the North Carolina Department of Environment, Health and Natural Resources, Division of Radiation Protection. Copies of regulations are available from the N.C. Department of Environment Health and Natural Resources, Division of Radiation Protection, P.O. Box 27687, Raleigh, NC 27611-7687 at a cost of sixteen dollars (\$16.00) each.

*Statutory Authority G.S. 131E-79.*

#### **.4802 RECORDS**

(a) A documented record on each imaging examination shall be included in the patient's medical record.

(b) Imaging reports shall be signed by the

physician interpreting the study.

(c) Copies of current reports made by private physicists or governing authority surveying the radiographic facilities shall be available to the Division.

*Statutory Authority G.S. 131E-79.*

#### **.4803 STAFFING**

(a) The staffing of the imaging department shall be determined by the radiologist in charge or by another person designated by hospital management.

(b) There shall be a minimum of one radiologic technologist available to the department on at least an on-call basis.

*Statutory Authority G.S. 131E-79.*

#### **.4804 MONITORING RADIATION EXPOSURE OF PERSONNEL**

(a) Facility management shall establish procedures for the monitoring of personnel and shall maintain a record for each individual working in the area of radiation where there is a reasonable probability of receiving one-fourth of the maximum permissible dose.

(b) Records documenting the monitoring of personnel receiving radiation exposure through the use of film badges or dosimeters must also be maintained by facility management. Readings from badges or dosimeters shall be recorded on at least a monthly basis.

(c) Upon termination of employment, each employee shall be provided with a summary of his exposure record.

(d) Permanent records of radiological exposure on all monitored personnel shall be maintained for review by the Division.

*Statutory Authority G.S. 131E-79.*

#### **.4805 SAFETY**

(a) Facility management shall ensure that all imaging equipment is operated under the supervision of a physician and by qualified personnel.

(b) Facility management shall ensure 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 Radiation Protection Services. Copies of the report shall be available for review by the Division.

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

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

(2) other representatives of the medical staff.

(e) All radio-active isotopes, whether for diagnostic, therapeutic, or research purposes shall be received, handled, and disposed of in accordance with the requirements of the North Carolina Department of Environment, Health, and Natural Resources, Division of Radiation Protection. Copies of regulations are available from the North Carolina Department of Environment, Health, and Natural Resources, Division of Radiation Protection, P.O. Box 27687, Raleigh, NC 27611-7687 at a cost of six dollars (\$6.00) each.

*Statutory Authority G.S. 131E-79.*

#### **.4806 NUCLEAR MEDICINE SERVICES**

When nuclear medicine services are offered, the governing board shall adopt written policies and procedures for the provision of those services which will ensure safety of patients and staff, management of radioactive isotopes and the maintenance of equipment according to the manufacturers' recommendations.

*Statutory Authority G.S. 131E-79.*

### **SECTION .4900 - LABORATORY SERVICES AND PATHOLOGY**

#### **.4901 ORGANIZATION**

The laboratory shall be under the supervision of a clinical pathologist or physician designated by the governing board, who has special training in clinical laboratory diagnosis.

*Statutory Authority G.S. 131E-79.*

#### **.4902 RECORDS**

(a) All requests for laboratory services shall be documented.

(b) All reports of laboratory services performed, including autopsy, shall be placed in the patient's medical record.

(c) Records of proficiency testing appropriate to the scope of services offered shall be available to the Division for review.

(d) Records of equipment calibration and quality



controls as recommended by the manufacturer shall be maintained and be available to the Division for review.

*Statutory Authority G.S. 131E-79.*

#### **.4903 STAFFING**

The clinical pathologist or his appointed designee, shall ensure that:

- (1) procedures and tests conducted are within the scope of the laboratory as approved by the hospital;
- (2) at least one qualified medical technologist is available at all times; and
- (3) qualified staff are available to carry out the functions of the laboratory.

*Statutory Authority G.S. 131E-79.*

#### **.4904 TESTS**

(a) Laboratory tests to be performed on a patient at the time of admission (if any) shall be established by the medical staff and be approved by the governing board of the hospital. In the event the medical staff and governing board elect not to establish routine laboratory tests for new admissions, the request for such tests shall be left to the discretion of the admitting physician.

(b) Serological tests for patients admitted shall be optional with the hospital. However, there shall be adequate records indicating that obstetrical patients have had a serological test during their current pregnancy.

(c) When laboratories outside of the facility are used, such laboratories must be approved by the governing board and medical staff of the facility. In case of such usage, a legible copy of the laboratory report must be included in the patient record.

*Statutory Authority G.S. 131E-79.*

#### **.4905 TISSUE REMOVAL AND DISPOSAL**

(a) The medical staff shall adopt written policies for pathological examination of tissue and specimens removed during surgery.

(b) Pathological waste disposal must comply with the rules Governing the Sanitation of Hospitals, Nursing and Rest Homes, Sanitariums, Sanatoriums, and Educational and Other Institutions, contained in 15A NCAC 18A .1300 which is hereby incorporated by reference including subsequent amendments and editions. Copies of 15A NCAC 18A .1300 may be obtained at no charge from the Environmental Health

Section, Health Division, North Carolina Department of Environment, Health and Natural Resources, P.O. Box 27687, Raleigh, NC 27611-7687.

*Statutory Authority G.S. 131E-79.*

#### **.4906 BLOOD BANK**

(a) Facilities which provide for procurement, storage and transfusion of blood shall meet the standards of the American Association of Blood Banks as outlined in the most current edition of Standards of Blood Banks and Transfusion Services available from the American Association of Blood Banks, 8101 Glenbrook Road, Bethesda, Maryland 20814-2749 at a cost of thirty-three dollars and fifty cents (\$33.50) per copy.

(b) The governing body shall approve the pathologist or physician as physician-in-charge of the blood bank service.

(c) Records shall be kept on file indicating the receipt and disposition of all blood handled. Care shall be taken to ascertain that blood administered has not exceeded its expiration date, and meets all criteria for safe administration.

(d) The facility shall make arrangements to secure on short notice all necessary supplies of blood, typed and cross-matched as required, for emergencies.

*Statutory Authority G.S. 131E-79.*

#### **.4907 MORGUE AND AUTOPSY FACILITIES**

(a) Morgue and autopsy services shall be provided either on site or by written agreement with a facility that provides those services.

(b) Procedures for the transport and storage of deceased patients shall be adopted by facility management.

(c) Procedures for post mortem cleaning of patients with diagnosed contagious diseases shall be adopted by the facility management.

*Statutory Authority G.S. 131E-79.*

### **SECTION .5000 - PHYSICAL REHABILITATION SERVICES**

#### **.5001 ORGANIZATION**

Facility management shall designate an individual responsible for the administration and supervision of each rehabilitation service.

*Statutory Authority G.S. 131E-79.*

#### .5002 DELIVERY OF CARE

(a) A member of the medical staff shall be responsible for the general medical care of the patient.

(b) The delivery of all rehabilitation services shall be provided by practitioners credentialed or licensed in their respective fields.

*Statutory Authority G.S. 131E-79.*

#### .5003 POLICIES AND PROCEDURES

Facility management shall establish written policies and procedures that include but are not limited to:

- (1) provision for assessment and evaluation of the services performed;
- (2) safety measures;
- (3) infection control measures; and
- (4) procedures for referral to other facilities for services not available on site.

*Statutory Authority G.S. 131E-79.*

#### .5004 PATIENT RECORDS

The patient record shall contain documentation of physical rehabilitation services utilized that include but is not limited to:

- (1) diagnosis to support the services requested;
- (2) assessment of patient's rehabilitative status;
- (3) re-assessment and progress of patient's rehabilitative status;
- (4) individualized plan of care and goals of rehabilitation; and
- (5) discharge plan.

*Statutory Authority G.S. 131E-79.*

#### .5005 CARDIAC REHABILITATION PROGRAM

When a facility elects to provide an outpatient cardiac rehabilitation program, the program shall be subject to rules 10 NCAC 3S, Section .0300-.1000 adopted by reference with all subsequent amendments. Referenced rules are available from the North Carolina Department of Human Resources, Division of Facility Services, Medical Facilities Licensure Section, 701 Barbour Drive, Raleigh, NC 27603 at a cost of three dollars (\$3.00) each.

*Statutory Authority G.S. 131E-79.*

### SECTION .5100 - INFECTION CONTROL

#### .5101 ORGANIZATION

(a) The governing body shall establish an infection control program that includes all patient care and patient care support services and departments for the surveillance, prevention and control of infection.

(b) The infection control committee shall include representatives of the medical staff, nursing staff, administration and the person directly responsible for the surveillance program activities.

(c) The infection control committee shall assume responsibility for the infection control program.

(d) Facility management shall designate a person to manage the infection control, prevention and surveillance program.

(e) The infection control committee shall involve facility departments and services as needed to maintain the infection control program.

*Statutory Authority G.S. 131E-79.*

#### .5102 POLICY AND PROCEDURES

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

- (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.



Statutory Authority G.S. 131E-79.

### .5103 LAUNDRY SERVICE

Facility management shall provide, directly or by contract, a laundry service or department that achieves the following:

- (1) 24 hour a day availability of clean linen for patient care needs; and
- (2) delivery of clean linen and removal of soiled linen in a manner that reduces the spread of infection.

Statutory Authority G.S. 131E-79.

### .5104 ENVIRONMENTAL SERVICES

Facility management shall ensure that environmental services (housekeeping) achieve the following:

- (1) 24 hour a day availability of personnel or supplies and equipment for the cleaning of patient rooms, patient care equipment, and the cleaning of spills;
- (2) a routine cleaning schedule for all areas of the facility to assist in the prevention and spread of disease; and
- (3) removal and appropriate disposal of waste materials including biologicals.

Statutory Authority G.S. 131E-79.

### .5105 STERILE SUPPLY SERVICES

Facility management shall ensure that services achieve the following:

- (1) decontamination and sterilization of equipment and supplies;
- (2) monitoring of sterilizing equipment on a routine schedule;
- (3) policies and procedures for the reuse of disposable items; and
- (4) policies and procedures addressing shelf life of stored sterile items.

Statutory Authority G.S. 131E-79.

## SECTION .5200 - PSYCHIATRIC SERVICES

### .5201 PSYCHIATRIC OR SUBSTANCE ABUSE SERVICES: APPLICABILITY OF RULES

The rules contained in this Section shall apply to all psychiatric and substance abuse services provided.

Statutory Authority G.S. 131E-79.

### .5202 DEFINITIONS APPLICABLE TO PSYCHIATRIC OR SUBSTANCE ABUSE SERVICES

(a) "Certified counselor" means an alcoholism, drug abuse or substance abuse counselor who is certified by the North Carolina Substance Abuse Professional Certification Board.

(b) "Certified substance abuse counselor/supervisor" means an individual who is a "certified counselor" as defined in 10 NCAC 3C .5202(a) and is designated by the North Carolina Substance Abuse Professional Certification Board as a qualified substance abuse supervisor.

(c) "Clinical/professional supervision" means regularly scheduled assistance by a qualified mental health, professional or a qualified substance abuse professional to a staff member who is providing direct, therapeutic intervention to a client or clients. The purpose of clinical supervision is to ensure that each client receives appropriate treatment or habilitation which is consistent with accepted standards of practice and the needs of the client.

(d) "Detoxification service" means a service provided in a unit or department whose primary purpose is to treat substance abuse through detoxification.

(e) "Direct care staff" means an individual who provides active direct care, treatment, or rehabilitation or habilitation services to clients on a continuous and regularly scheduled basis.

(f) "Psychiatric nurse" means an individual who is licensed to practice as a registered nurse in North Carolina by the North Carolina Board of Nursing and who is a graduate of an accredited master's level program in psychiatric mental health nursing with two years of experience or has a master's degree in behavioral science with two years of supervised clinical experience in psychiatric mental health nursing or has four years of supervised clinical experience in psychiatric mental health nursing.

(g) "Psychiatric service" means a service provided in a unit or department whose primary purpose is to treat mental illness.

(h) "Psychiatric social worker" means an individual who holds a master's degree in social work from an accredited school of social work and has two years of clinical social work experience.

(i) "Psychiatrist" means an individual who is licensed to practice medicine in North Carolina and who has completed an accredited training program in psychiatry.

(j) "Psychologist" means an individual licensed to practice psychology in North Carolina by the

North Carolina State Board of Examiners of Practicing Psychologists.

(k) "Qualified mental health professional" means any one of the following: psychiatrist, psychiatric nurse, practicing psychologist, psychiatric social worker, an individual with at least a masters degree in a related human service field and two years of supervised clinical experience in mental health services or an individual with a baccalaureate degree in a related human service field and four years of supervised clinical experience in mental health services.

(l) "Qualified substance abuse professional" means an individual who is:

- (1) certified by the North Carolina Substance Abuse Professional Certification Board;
- (2) certified by the National Consortium of Chemical Dependency Nurses, Inc; or
- (3) a graduate of a college or university with a baccalaureate or advanced degree in a human service related field with documentation of at least two years of supervised experience in the profession of alcoholism and drug abuse counseling.

(m) "Restraint" means the limitation of one's freedom of movement and includes the following:

- (1) mechanical restraint which means restraint of a client with the intent of controlling behavior with mechanical devices which include, but are not limited to, cuff, ankle straps, sheets or restraining shirts; or
- (2) physical restraint which means restraint of a client until calm. As used in these Rules, the term physical restraint does not apply to the use of professionally recognized methods for therapeutic holds of brief duration (five minutes or less).

(n) "Restrictive facility" means a facility so designated by the Division which uses mechanical is proposed to be adopted as follows: restraint or seclusion in accordance with G.S. 122C-60 in order to restrain a client's freedom of movement.

(o) "Seclusion" means isolating a client in a separate locked room for the purpose of controlling a client's behavior.

(p) "Substance abuse service" means service provided in a unit or department whose primary purpose is to treat substance abuse.

*Statutory Authority G.S. 131E-79.*

## **.5203 STAFFING FOR PSYCHIATRIC OR SUBSTANCE ABUSE SERVICES**

### **(a) General Requirements:**

- (1) A physician shall be present in the facility or on call 24 hours per day. The medical appraisal and medical treatment of each patient shall be the responsibility of a physician;
- (2) Each facility shall determine its overall staffing requirements based upon the age categories (child, adolescent, adult, elderly), clinical characteristics, treatment requirements and numbers of patients;
- (3) There shall be a sufficient number of appropriately qualified clinical and support staff to assess and address the clinical needs of the patients;
- (4) Staff members shall have training or experience in the provision of care in each of the age categories assigned for treatment.

### **(b) Psychiatric Services:**

- (1) Staff coverage for psychiatric services shall include at least one each of the following: psychiatrist, psychiatric nurse, psychologist, and psychiatric social worker;
- (2) A qualified mental health professional shall be available by telephone or page and able to reach the facility within 30 minutes on a 24 hour basis;
- (3) Each clinical or direct care staff member who is not a qualified mental health professional shall receive professional supervision from a qualified mental health professional;
- (4) When detoxification services are provided, there shall be liaison and consultation with a qualified substance abuse professional prior to the discharge of a client.

### **(c) Substance Abuse Services:**

- (1) At least one registered nurse shall be on duty during each shift;
- (2) Certified substance abuse counselors or qualified substance abuse professionals shall be employed at the ratio of one staff member for each 10 inpatients or fraction thereof. In documented instances of bona fide shortages of certified persons, uncertified individuals expecting to become certified may be employed for a maximum of 38 months without qualifications;



(3) The facility shall have a minimum of two staff members providing care, treatment and services directly to patients on duty at all times and maintain a shift ratio of one staff member for each 20 or less inpatients with the following exceptions:

(A) When there are minor inpatients there shall be staff available on the ratio of one staff member for each five minor inpatients or fraction thereof during each shift from 7:00 a.m. - 11:00 p.m.;

(B) When detox services are offered there shall be no less than one staff member for each nine inpatients or fraction thereof on each shift.

*Statutory Authority G.S. 131E-79.*

#### **.5204 PSYCHIATRIC OR SUBSTANCE ABUSE SERVICES RECORD REQUIREMENTS**

(a) In addition to the general record keeping requirements of 10 NCAC 3C .3906, specialized assessment and treatment plans for individuals undergoing psychiatric or substance abuse treatment are as follows:

(1) Within 24 hours following admission each individual shall have a completed admission assessment. The initial assessment shall include the reason for admission, admitting diagnosis, mental status including suicide potential, diagnostic tests or evaluations, and a determination of the need for additional information to include the potential for the physical abuse of self or others and a family assessment when a minor is involved;

(2) Within 72 hours following admission, a preliminary individual treatment plan shall be completed and implemented; and

(3) Within ten days following admission, a comprehensive individual treatment plan shall be developed and implemented. For outpatient programs the plan shall be developed and implemented within 30 days of admission to treatment.

(b) Individual treatment plans for psychiatric and substance abuse patients shall be developed in partnership with the patient or individual acting on behalf of the patient. Clinical responsibility for

the development and implementation of the plan shall be clearly designated. Minimum components of the comprehensive treatment plan shall include diagnosis and time specific short and long term measurable goals, strategies for reaching goals, and staff responsibility for plan implementation. The plan shall be revised as medically or clinically indicated.

(c) Progress notes shall be entered in each individual's record. Included is information which may have a significant impact on the individual's condition or expected outcome such as family conferences or major events related to the patient. Patient status shall be documented each shift for any inpatient psychiatric or substance abuse services, and on a per visit basis for outpatient psychiatric and substance abuse services.

(d) For each individual to whom substance abuse services are provided, a written plan for aftercare services shall be developed which minimally includes:

- (1) plan for delivering aftercare services, including the aftercare services which are provided; and
- (2) provision for agreements with individuals or organizations if aftercare services are not provided directly by the facility.

*Statutory Authority G.S. 131E-79.*

#### **.5205 SECLUSION**

At least one seclusion room shall be provided in all hospitals licensed to provide a psychiatric program, a substance abuse program or both.

*Statutory Authority G.S. 131E-79.*

#### **.5206 COMPLIANCE WITH STATUTORY REQUIREMENTS**

(a) Facilities providing psychiatric or substance abuse services shall develop procedures to ensure the rights of psychiatric and substance abuse patients in accordance with North Carolina statutes addressing the rights of psychiatric and substance abuse patients. Statutes addressing such rights are as follows:

- (1) G.S. 122C-51. Declaration of policy on clients' rights;
- (2) G.S. 122C-52. Right to confidentiality;
- (3) G.S. 122C-53. Exceptions; client;
- (4) G.S. 122C-54. Exceptions; abuse reports and court proceedings;
- (5) G.S. 122C-55. Exceptions; care and treatment;

- (6) G.S. 122C-56. Exceptions; research and planning;
- (7) G.S. 122C-57. Right to treatment and consent to treatment;
- (8) G.S. 122C-58. Civil rights and civil remedies;
- (9) G.S. 122C-59. Use of corporal punishment;
- (10) G.S. 122C-60. Use of physical restraints or seclusion;
- (11) G.S. 122C-61. Treatment rights in 24-hour facilities;
- (12) G.S. 122C-62. Additional rights in 24-hour facilities;
- (13) G.S. 122C-65. Offenses relating to clients; and
- (14) G.S. 122C-66. Protection from abuse and exploitation; reporting.

(b) Facilities providing psychiatric or substance abuse services shall develop procedures to protect confidentiality of information regarding communicable disease and conditions in compliance with G.S. 130A-143.

*Statutory Authority G.S. 131E-79.*

#### **.5207 PSYCHIATRIC OR SUBSTANCE ABUSE OUTPATIENT SERVICES**

Partial hospitalization, outpatient and day treatment facilities shall be subject to rules 10 NCAC 14L .0300, 10 NCAC 14N .0700, and 10 NCAC 14N .0900 respectively and adopted by reference with all subsequent amendments. Referenced rules are available from the N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Quality Improvement Section, 325 North Salisbury Street, Raleigh, NC 27603-5906 at a cost of five dollars and seventy-five cents (\$5.75) per copy.

*Statutory Authority G.S. 131E-79.*

#### **SECTION .5300 - SUPPLEMENTAL RULES FOR THE LICENSURE OF THE NURSING FACILITY BEDS; DOMICILIARY BEDS IN A HOSPITAL**

##### **.5301 SUPPLEMENTAL RULES**

When a facility offers nursing facility services or domiciliary care services, the services shall be included under one hospital license as provided in Rule .3101 of this Subchapter. The nursing facility care and domiciliary care unit shall meet the supplemental requirements of this Section in

addition to all other applicable rules in this Subchapter.

*Statutory Authority G.S. 131E-79.*

##### **.5302 DEFINITIONS**

The following definitions shall apply throughout this Section:

- (1) "Abuse" means the willful infliction of physical pain, injury, mental anguish or unreasonable confinement which may cause or result in temporary or permanent mental or physical injury, pain, harm or death. Abuse includes, but is not limited to, the following:
  - (a) Verbal abuse - any use of oral, written or gestured language which a reasonable person would view as disparaging and derogatory terms to a patient regardless of his or her age, ability to comprehend or disability;
  - (b) Sexual abuse - sexual harassment, sexual coercion or sexual assault of a patient;
  - (c) Physical abuse - hitting, slapping, kicking or corporal punishment of a patient;
  - (d) Mental abuse - language or treatment which would be viewed by a reasonable person as involving humiliation, harassment, threats of punishment or deprivation of a patient;
  - (e) Unreasonable confinement - the separation of a patient from other persons, or from his or her room, against the patient's will or the will of the patient's legal representative. Unreasonable confinement does not include emergency or short-term monitored separation used as therapeutic intervention to reduce agitation until a plan of care is developed to meet the patient's needs.
- (2) "Accident" means something occurring by chance or without intention which has caused physical or mental harm to a patient, resident or employee;
- (3) "Administer" means the direct application of a drug to the body of a patient by injection, inhalation, ingestion or other means;
- (4) "Administrator" means the person who has authority for and is responsible to the governing board for the overall operation of a nursing facility or domiciliary care



- facility;
- (5) "Brain injury long term care" is defined as an inter-disciplinary, intensive maintenance program for patients who have incurred brain damage caused by external physical trauma and who have completed a primary course of rehabilitative treatment and have reached a point of no gain or progress for more than three consecutive months. Services are provided through a medically supervised interdisciplinary process and are directed toward maintaining the individual at the optimal level of physical, cognitive and behavioral functioning;
- (6) "Combination facility" means any facility with nursing facility beds (nursing home beds) which is licensed to provide more than one level of care;
- (7) "Convalescent care" means care given for the purpose of assisting the patient or resident to regain health or strength;
- (8) "Director of Nursing" means the registered nurse who has authority and direct responsibility for all nursing services and nursing care on the nursing facility;
- (9) "Dispense" means preparing and packaging a prescription drug or device in a container and labeling the container with information required by state and federal law. Filling or refilling drug containers with prescription drugs for subsequent use by a patient is "dispensing". Providing quantities of unit dose prescription drugs for subsequent administration is "dispensing";
- (10) "Drug" or "medication" means substances;
- (a) recognized in the official United States Pharmacopoeia, official National Formulary, or any supplement to any of them;
- (b) intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals;
- (c) intended to affect the structure or any function of the body of man or other animals, i.e., substances other than food; and
- (d) intended for use as a component of any article specified in Paragraphs (a), (b), or (c) of this Subparagraph; but does not include devices or their components, parts, or accessories.
- (11) "Duly licensed" means holding a current and valid license as required under the General Statutes of North Carolina;
- (12) "Existing facility" means a licensed facility;
- (13) "Exit conference" means the conference held at the end of a survey, inspection or investigation, but prior to finalizing the same, between the department's representatives who conducted the survey, inspection or investigation and a facility's representative(s);
- (14) "Incident" means an intentional or unintentional action, occurrence or event which is likely to cause or lead to physical or mental harm to a patient, resident or employee;
- (15) "Licensed Practical Nurse" means a nurse who is duly licensed as a practical nurse under G.S. 90, Article 9A;
- (16) "Licensee" means the person, firm, partnership, association, corporation or organization to whom a license has been issued;
- (17) "Misappropriation of property" means the criminal taking, use, exploitation of, destruction of, or damage to, a patient's belongings or money. The Department must prove the misappropriation of property by a preponderance of the evidence. Conviction of the criminal act is not a prerequisite to placing a finding concerning the misappropriation of property on the North Carolina Nurse Aide Registry;
- (18) "Neglect" means a failure through a lack of attention, carelessness, or omission, to provide timely and consistent services, treatment or care to a patient or patients which are necessary to obtain or maintain the patient's or patients' health, safety or comfort;
- (19) "New facility" means a proposed facility, a proposed addition to an existing facility or a proposed remodeled portion of an existing facility. If it is determined by the department that more than one half of an existing facility is remodeled, the entire existing facility shall be considered a new facility;
- (20) "Nurse Aide" means any individual providing nursing-related services to patients in a facility, who is not a

licensed health professional, a registered dietitian or someone who volunteers to provide such services without pay, and who is listed on the North Carolina Nurse Aide registry;

- (21) "Nurse Aide Trainee" means an individual who has not completed an approved nurse aide training course and competency evaluation but is performing tasks for which they have been found proficient by an instructor. These tasks shall be performed under the direct supervision of a registered nurse. The term does not apply to volunteers;
- (22) "On duty" means personnel who are awake, dressed, responsive to patient needs and physically present in the facility performing assigned duties;
- (23) "Patient" means any person admitted for care to a nursing facility;
- (24) "Physician" means a person licensed under G.S. 90, Article 1 to practice medicine in North Carolina;
- (25) "Registered Nurse" means a nurse who is duly licensed as a registered nurse under G.S. 90, Article 9A;
- (26) "Resident" means any person admitted for care to a domiciliary home;
- (27) "Restorative nursing care" means the plan and delivery of care to attain and maintain the patient's pre-illness level of function;
- (28) "Sitter" means an individual employed to provide companionship and social interaction to a particular resident or patient, usually on a private duty basis;
- (29) "Ventilator dependence" is defined as physiological dependency by a patient on the use of a ventilator for more than eight hours a day.

*Statutory Authority G.S. 131E-79.*

### **.5303 INSPECTIONS**

(a) Any facility with beds licensed by the Department under this Section may be inspected by one or more authorized representative of the Division at any time. Generally, inspections will be conducted between the hours of 8:00 a.m. and 6:00 p.m., Monday through Friday. However, complaint investigations shall be conducted at the most appropriate time for investigating the complaint.

(b) At the time of inspection, the authorized representative of the Division shall make his

presence known to the administrator or other person in charge who shall cooperate with such representative and facilitate the inspection.

*Statutory Authority G.S. 131E-79.*

### **.5304 ADMISSIONS**

(a) No patient or resident shall be admitted except under the orders of a North Carolina licensed physician.

(b) The nursing facility shall acquire prior to or at the time of admission orders from the attending physician for the immediate care of the patient or resident.

(c) Within 48 hours of admission, the facility shall acquire medical information which shall include current medical findings, diagnosis, rehabilitation potential, a summary of the facility stay if the patient or resident is being transferred from a facility, and orders for the ongoing care of the patient or resident.

(d) If a patient is admitted from somewhere other than a facility, a physical examination shall be performed either within five days prior to admission or within 48 hours following admission.

(e) Facilities offering nursing facility or domiciliary home care as a new service must prepare a plan of admission which, at a minimum, ensures availability of staff time and plans for individual patient assessments, initiation of health care or nursing care plans, and implementation of physician and nursing treatment plans. This plan shall be available for inspection during the initial licensure survey prior to issuance of a license.

(f) Only persons who are 18 years of age or older shall be admitted to domiciliary home beds.

*Statutory Authority G.S. 131E-79.*

### **.5305 POLICIES AND PROCEDURES**

The governing board shall ensure the development of written policies and procedures which shall be available to and implemented by staff. These policies and procedures shall cover at least the following areas:

- (1) admissions and transfers;
- (2) discharges with physician orders and patients or residents leaving against physician advice;
- (3) nutrition and dietetic services;
- (4) gratuities and solicitation policies which at a minimum shall provide that no owner, operator, agent or employee of a facility nor any member of his family shall accept a gratuity directly or



indirectly from a patient or resident in the facility or solicit for any type of contribution;

- (5) housekeeping;
- (6) infection control which include, but not limited to, requirements for sterile, aseptic and isolation techniques; and communicable disease screening including, at a minimum annual tuberculosis screening for all staff and inpatients of the facility;
- (7) screening and reporting communicable disease to the local health department;
- (8) orientation of all facility personnel;
- (9) patient or resident care plans, treatment and other health care or nursing care, including but not limited to all policies and procedures required by rules contained in this Subchapter;
- (10) patients' or residents' rights;
- (11) physical evaluation for residents and patients at least annually;
- (12) physician services and utilization of the individual's private physician;
- (13) procurement of supplies and equipment to meet individual patient care needs;
- (14) protection of patients from abuse and neglect;
- (15) rehabilitation services;
- (16) release of medical record information; and
- (17) maintenance of patient medical or health care records including charging or record keeping.

*Statutory Authority G.S. 131E-79.*

#### **.5306 GENERAL**

The governing board shall ensure that policies and procedures are available and implemented for assessing each patient's or resident's health care needs and for planning to meet identified health care needs. There shall be a system for evaluating the effectiveness of the nursing care assessment, planning and implementation (delivery of care processes) for each patient or resident.

*Statutory Authority G.S. 131E-79.*

#### **.5307 ASSESSMENT AND PLANNING**

Each patient's and resident's condition shall be assessed on a regular, periodic basis, at least quarterly, with appropriate notation and updating of the health plan of care. Health care planning for each patient and resident shall be an on-going

interdisciplinary process and shall include, but not be limited to, the following:

- (1) data which is systematically and continuously collected about the patient's or resident's health status; and which shall be recorded so as to be accessible to all staff involved in the patient's or resident's care;
- (2) current problems or needs shall be identified and prioritized from a completed assessment; and
- (3) a current plan of care developed in conjunction with the patient, resident or legal guardian that includes measurable time-related goals and approaches, or measures to be employed by various disciplines in order to achieve the identified goals.

*Statutory Authority G.S. 131E-79.*

#### **.5308 IMPLEMENTATION OF HEALTH PLAN**

All parts of the plan of care shall be assigned to specific disciplines or staff as indicated in the plan of care to ensure that health care and rehabilitative services are performed daily and documented for those patients and residents who require such services.

*Statutory Authority G.S. 131E-79.*

#### **.5309 NURSING/HEALTH CARE ADMINISTRATION AND SUPERVISION**

(a) A hospital nursing facility or unit shall have a director of nursing service who shall be responsible for the overall organization and management of all nursing services. The director of nursing service shall be currently licensed to practice as a registered nurse by the North Carolina Board of Nursing in accordance with G.S. 90, Article 9A.

(b) A facility or unit shall not be licensed unless it has a director of nursing or acting director or nursing.

(c) The director of nursing shall not serve as administrator or assistant administrator.

(d) A facility shall provide a full-time director of nursing on duty at least eight hours per day, five days a week.

(e) The director of nursing shall cause the following to be accomplished:

- (1) establishment and implementation of nursing policies and procedures which shall include, but shall not be limited to

the following:

- (A) daily charting of any unusual occurrences or acute episodes related to patient care, and progress notes written monthly reporting each patient's performance in accordance with identified goals and objectives and each patient's progress toward rehabilitative nursing goals;
- (B) assurance of the delivery of nursing services in accordance with physicians' orders, nursing care plans and the facility's policies and procedures;
- (C) notification of emergency physicians or on-call physicians;
- (D) infection control to prevent cross-infection among patients and staff;
- (E) reporting of deaths;
- (F) emergency reporting of fire, patient and staff accidents or incidents, or other emergency situations;
- (G) use of protective devices or restraints to ensure that each patient or resident is restrained in accordance with physician orders and the facility's policies, and that the restrained patient or resident is appropriately evaluated and released at a minimum of every two hours;
- (H) special skin care and decubiti care;
- (I) bowel and bladder training;
- (J) maintenance of proper body alignment and restorative nursing care;
- (K) supervising and assisting patients with feeding;
- (L) intake and output observation and reporting for those patients whose condition warrants monitoring of their fluid balance. This will include those patients on intravenous fluids or tube feedings, and patients with kidney failure and temperatures elevated to 102 degrees Fahrenheit or above;
- (M) catheter care; and
- (N) procedures used in caring for patients in the facility;
- (2) develop written job descriptions for nursing personnel;
- (3) periodic assessment of the nursing department and identification of personnel requirements as they relate to patient care needs and reporting same to the administrator;
- (4) orientation plan and continuing

inservice education program for nursing employees and documentation of staff attendance and subject matter covered during inservice education programs;

- (5) provide appropriate reference materials for the nursing department, which includes a Physician's Desk Reference or comparable drug reference, policy and procedure manual, and medical dictionary for each nursing station; and
- (6) establish of operational procedures to ensure that appropriate supplies and equipment are available to nursing staff as determined by individual patient care needs.

*Statutory Authority G.S. 131E-79.*

### **.5310 NURSE STAFFING REQUIREMENTS**

(a) A hospital nursing facility or unit shall provide licensed nursing personnel sufficient to accomplished the following:

- (1) patient needs assessment;
- (2) patient care planning; and
- (3) supervisory functions in accordance with the level of patient or resident care advertised or offered by the facility.

The facility also shall provide additional nursing personnel sufficient to ensure that the activities of daily living, personal grooming, restorative nursing actions and other health care needs identified in each patient's or resident's plan of care are met.

(b) A multi-storied facility shall provide at least one direct care staff member on duty on each patient care floor at all times.

(c) Daily direct patient care nursing staff, licensed and unlicensed, shall equal or exceed 2.1 nursing hours per patient. (nursing hours per patient day or NHPPD or NH/PD.)

(d) At least one licensed nurse shall be on duty for direct patient care at all times.

(e) A registered nurse shall be on duty for at least eight consecutive hours a day, seven days a week. The Director of Nursing may be counted as meeting the requirements for both the director of nursing and patient and resident care staffing for facilities of a total census of 60 beds or less.

(f) Nursing support personnel, including ward clerks, secretaries, nurse educators and persons primarily in administrative management positions and not actively involved in direct patient care shall not be counted toward compliance with minimum daily requirements for direct care



staffing.

(g) A facility shall not employ or contract, as a nurse aide, any individual not listed on the North Carolina Nurse Aide Registry, unless the individual is enrolled full-time in a nurse aide training and competency evaluation program approved by the Department; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program approved by the Department and has not yet been included in the registry. Facilities must follow up to ensure that such individuals actually become registered.

(h) The facility shall maintain an accurate record of qualifications and in-service training for each nurse aide employed by the facility. The facility shall provide, to the Department upon request, verification of employment of any nurse aide employed by the facility in the previous 12 months.

Statutory Authority G.S. 131E-79.

#### **.5311 DOMICILIARY HOME PERSONNEL REQUIREMENTS**

(a) The administrator shall designate a person to be in charge of the domiciliary home residents at all times.

(b) If domiciliary home beds are located in a separate building or a separate level of the same building, there shall be a person on duty in the domiciliary home areas at all times.

(c) A facility shall provide sufficient staff to ensure that activities of daily living, personal grooming, and assistance with eating are provided to each resident. Medication administration as indicated by each resident's condition or physician's orders shall be carried out as identified in each resident's plan of care.

(d) Domiciliary home facilities (Home for the Aged beds) licensed as a part of a combination facility shall comply with the staffing requirements of 10 NCAC 42D .1407 as adopted by the Social Services Commission for freestanding domiciliary homes and any subsequent amendments thereto.

Statutory Authority G.S. 131E-79.

#### **.5312 REHABILITATIVE NURSING AND DECUBITUS CARE**

Each patient or resident shall be given care coordinated by the registered nurse to prevent contractures, deformities, and decubiti, including but not limited to:

(1) changing positions of bedfast and

chairfast patients or residents every two hours and administering simple preventive care. Documentation of such care and outcome must be included in routine summaries or progress notes;

(2) maintaining proper alignment and joint movement to prevent contractures and deformities. Documentation of such care must be included in routine summaries or progress notes;

(3) implementing an individualized bowel and bladder training program except for patients or residents whose records document that such training is not effective. A monthly summary for patients and quarterly summaries for domiciliary residents shall be written relative to each patient's or resident's performance in the bowel and bladder training program;

(4) providing adequate nutrition and hydration; and

(5) such other services as are necessary to meet the needs of the patient.

Statutory Authority G.S. 131E-79.

#### **.5313 MEDICATION ADMINISTRATION**

(a) The administration of medication in nursing facility units shall comply with Rule .4511(a) of this Subchapter.

(b) Verbal and telephone orders shall be countersigned by a physician within five days of issuance.

Statutory Authority G.S. 131E-79.

#### **.5314 TRAINING**

(a) A hospital nursing facility or unit shall provide all employees a planned orientation and continuing education program emphasizing all patient or resident care policies and procedures, patients' rights, and staff performance expectations. Attendance and subject matter covered shall be documented for each session and available for licensure inspections.

(b) The administrator shall ensure that each new employee is oriented to the facility's philosophy and goals within the first week of employment.

(c) Each employee shall have specific on-the-job training as necessary for the employee to properly perform his individual job assignment.

(d) Unless otherwise prohibited, a nurse aide trainee may be employed to perform the duties of a nurse aide for a period of time not to exceed

four months. During this period of time the nurse aide trainee shall be permitted to perform only those tasks for which minimum acceptable competence has been demonstrated and documented on a skills check-off record. Job applicants for nurse aide positions who were formerly qualified nurse aides but have not been gainfully employed as such for a period of 24 consecutive months or more shall be employed only as nurse aide trainees and must re-qualify as nurse aides within four months of employment by successfully passing an approved competency evaluation. An accurate record of nurse aide qualifications shall be maintained for each nurse aide employed by the facility and shall be retained in the general personnel files of the facility.

(c) The curriculum content required for nurse aide level 1 education programs shall be subject to approval by the Division and shall include, as a minimum, basic nursing skills, personal care skills, cognitive, behavioral and social care, basic restorative services, and patients' rights. The minimum number of course hours shall be 75, of which at least 20 hours shall be in the classroom and at least 40 hours shall be supervised practical experience. The initial orientation to the facility shall not be counted in the 75 hour training program. Competency evaluation shall be conducted in each of the following areas:

- (1) observation and documentation;
- (2) basic nursing skills;
- (3) personal care skills;
- (4) mental health and social service needs;
- (5) basic restorative services; and
- (6) Residents' Rights.

(f) Successful course completion and skill competency shall be determined by competency evaluation approved by the Division. Nurse aides who have formerly been fully qualified under nurse aide training requirements may re-establish their qualifications by successfully passing a competency evaluation test.

*Statutory Authority G.S. 131E-79.*

#### **.5315 DENTAL CARE**

(a) A dental examination shall be performed at the time of admission by a dentist or registered nurse. The results of the exam shall be placed in the patient's or resident's medical or health care record and shall include:

- (1) type of diet which the patient or resident can best manage (such as normal, soft or pureed);
- (2) the presence of infection of gums,

teeth, or jaws;

- (3) brief descriptions of any removable dental appliances and a statement of their condition; and
- (4) indications for dental treatment at the time of admission.

(b) Names of dentists who have agreed to render emergency dental care shall be maintained at each nursing station in the nursing facility or unit and at the supervisor's station in a domiciliary home.

(c) Staff of the facility shall ensure that:

- (1) necessary daily dental care is provided;
- (2) each patient or resident possesses appropriate toothbrushes and is encouraged and, when necessary, assisted in their use; and
- (3) each patient or resident having a removable denture is furnished a receptacle in which to immerse the denture in water overnight.

*Statutory Authority G.S. 131E-79.*

#### **.5316 AVAILABILITY OF PHARMACEUTICAL SERVICES**

(a) A hospital nursing facility or unit shall provide pharmaceutical services under the supervision of a pharmacist.

(b) A hospital nursing facility or unit shall be responsible for obtaining drugs, therapeutic nutrients and related products prescribed or ordered by a physician for patients or residents in the facility.

(c) Services shall include documented on-site pharmaceutical assessments accomplished at least every 31 calendar days for all patients and residents.

(d) Hospital nursing facility or unit management shall ensure that action is taken in response to the recommendations made by the pharmacist.

*Statutory Authority G.S. 131E-79.*

#### **.5317 DINING FACILITIES**

Patients, including wheelchair patients, shall be encouraged to eat at the tables in the dining area and shall be assisted when necessary by other than dietetic staff. Tables shall be of adequate height to accommodate wheelchair patients. An overbed table shall be provided for patients who eat in bed.

*Statutory Authority G.S. 131E-79.*

#### **.5318 ACTIVITIES AND RECREATION**

- (a) The administrator shall designate an



activities and recreation director to be in charge of activities and recreation for all patients and residents. The activities and recreation director shall have training and experience in directing recreational and group activities. The activities and recreation director shall be under the supervision of the administrator and shall be qualified to meet the needs of the patients and residents. Any director hired on or after the effective amended date of this Rule shall be a qualified professional who:

- (1) Is a therapeutic recreation specialist or therapeutic recreation assistant certified by the North Carolina State Board of Therapeutic Recreation Certification pursuant to G.S. 90C-9 or is eligible for certification as a therapeutic recreation specialist by a recognized accrediting body;
- (2) Has had two years of experience in a social or recreation program within the last five years, one of which was full-time in a resident activities program in a health care setting;
- (3) Is a qualified occupational therapist or occupational therapy assistant licensed as such by the North Carolina Board of Occupational Therapy pursuant to G.S. 90-270.70;
- (4) Is certified by the National Certification Council for Activity Professionals; or
- (5) Has completed an activities training course approved by the State.

(b) The hospital nursing facility shall maintain and make available a listing of local resources for activities and recreation to be utilized in meeting the needs and interests of all patients and residents.

(c) Restoration to self care and resumption of normal activity shall be one of the main goals of the recreation and activity program. The scope of the activity program shall include:

- (1) social activities involving individual and group participation which are designed to promote group relationship;
- (2) indoor and outdoor recreational activities;
- (3) opportunity to participate in activities outside the facility;
- (4) opportunity to attend the church or religious program of his choice;
- (5) creative and expressive activities;
- (6) educational activities; and
- (7) exercise.

(d) The facility shall develop written policies and procedures which shall:

- (1) attempt to prevent the further mental or physical deterioration for those patients or residents who cannot realistically resume normal activities;
- (2) ensure opportunities for patient involvement, both individual and group, in both planning and implementing the activity program;
- (3) provide patients or residents the opportunity for choice among a variety of activities; and
- (4) encourage participation by each patient or resident in social and recreational activities according to individual need and abilities and desires unless the patient's or resident's record contains documentation that he is unable to participate.

(e) Each patient's or resident's activity plan shall be a part of his overall plan of care and shall contain documentation of periodic assessments of the individual's activity needs and interests.

(f) A record of the activities offered and individuals participating in them shall be maintained in the facility.

(g) A hospital nursing facility or unit shall display a monthly activities calendar which includes variety to appeal to different interest groups in the care and domiciliary home services.

(h) A nursing facility or unit shall provide:

- (1) Space for recreational and diversional activities. In hospitals offering new nursing home services, space shall be provided separately from the main living and dining areas; however, these areas may also be used for social activities;
- (2) Designated indoor and outdoor activity areas for independent and group needs of patients and residents, and which are:
  - (A) accessible to wheelchair and ambulatory patients; and
  - (B) of sufficient size to accommodate necessary equipment and permit unobstructed movement of wheelchair and ambulatory patients or personnel responsible for instruction and supervision; and
- (3) Adequate space to store equipment and supplies without blocking exists or otherwise threatening the health and safety of patients and residents.

(i) There shall be equipment and supplies sufficient to carry out planned programs for both

individual and group activities.

*Statutory Authority G.S. 131E-79.*

### **.5319 SOCIAL SERVICES**

(a) The administrator shall designate an employee to be responsible for the provision of social services. This person shall be known as the social services director. Subsequent to the effective date of the rules contained in this Subchapter, any newly designated person must be a graduate of a four year college or university with one year's experience in the health care or long term care field or have an equivalent combination of education and experience. An equivalent combination of education and experience means the number of years of education leading to a baccalaureate or associate degree plus the number of years of long term nursing facility experience equal to five years; or eligible for certification as a social worker pursuant to G.S. 90B-7. The social services director shall have authority to carry out provisions contained in Paragraph (b) of this Rule.

(b) Each patient's or resident's plan of care shall contain a written plan for meeting his individual social needs which shall involve active participation. The plan shall address the following:

- (1) needed assistance in meeting the patient's or resident's physical, social and emotional needs through consultation with the patient or resident, legal guardian, relative, physician or others;
- (2) assisting the patient or resident in adjusting to his environment;
- (3) referral to other supporting resources for protective services, for financial services and for assistance at the time of discharge or transfer into a new environment; and
- (4) the utilization of caseworkers employed by the county department of social services in the case of recipients of public assistance and for the utilization of appropriate persons with experience and training in the general area of social work in the case of those not on public assistance.

(c) Discharge planning shall be in keeping with each patient's and resident's discharge needs. These are as follows:

- (1) The administrator shall ensure that a medical order for discharge, including

any special instructions for meeting rehabilitation potential, is obtained for all patients or residents except when a patient or resident leaves against a physician's order or advice; and

- (2) The social services director shall coordinate discharge instructions and ensure that patients, residents and their families have received the instructions.

*Statutory Authority G.S. 131E-79.*

### **.5320 RESTRAINTS**

(a) Patients and residents shall be restrained only by physician order.

(b) The nurse in charge shall be responsible for making the decision relative to necessity for, type and duration of restraint in emergency situation requiring restraints while contacting the physician. The nurse also shall be responsible for documenting same in the patient's or resident's record.

(c) The type of restraint used and the time of application and removal shall be recorded by a nurse in the patient's or resident's record.

(d) Chemical restraint shall be justified by a physician in the patient's medical record. Orders shall be time specific and address the outcome desired.

*Statutory Authority G.S. 131E-79.*

### **.5321 NURSING HOME PATIENT OR RESIDENT RIGHTS**

(a) Written policies and procedures shall be developed and enforced to implement requirements in G.S. 131E-115 et seq. (Nursing Home Patients Bill of Rights) concerning the rights of patients and residents. The administrator shall make these policies and procedures known to the staff, patients and residents, and families of patients and residents and shall ensure their availability to the public by placing them in a conspicuous place.

(b) Any violation of patient rights contained in G.S. 131E-117 shall be determined by representatives of the Division by investigation or survey.

(c) If a facility is found to be in violation of any of the rights contained in G.S. 131E-117, the Division shall impose penalties for each violation as provided by G.S. 131E-129.

(d) When the Department has been notified that corrective action has been taken for each violation, verification of same shall be made by a representative of the Division.



(e) The Department shall calculate a total of all fines levied against a facility based on the number of violations and the number of days and patients or residents involved in each violation.

(f) The Department shall mail a statement to the facility showing a total fine for each violation and a total of fines due to be paid for all violations. The facility shall pay the penalty within 60 days unless a hearing is requested under G.S. 150B.

(g) When it is found that a violation of G.S. 131E-117 has occurred but corrective action was taken prior to the date of discovery, fines shall be calculated and assessed in accordance with Paragraphs (e) and (f) of this Rule.

*Statutory Authority G.S. 131E-79.*

#### **.5322 BRAIN INJURY EXTENDED CARE PHYSICIAN SERVICES**

(a) For nursing facility patients located in designated brain injury long-term care units, there shall be an attending physician who is responsible for the patient's specialized care program. The intensity of the program requires that there shall be direct patient contact by a physician at least once per week and more often as the patient's condition warrants. Each patient's interdisciplinary, long term care program shall be developed and implemented under the supervision of a physiatrist (a physician trained in Physical Medicine and Rehabilitation) or a physician of equivalent training and experience appointed by the governing body.

(b) If a physiatrist or physician of equivalent training or experience is not available on a weekly basis to the facility, the facility shall provide for weekly medical management of the patient, by another physician. In addition, oversight for the patient's interdisciplinary, long term care program shall be provided by a qualified consultant physician who visits patients monthly, makes recommendations for and approves the interdisciplinary care plan, and provides consultation as requested to the physician who is managing the patient on a weekly basis.

(c) The attending physician shall actively participate in individual case conferences or care planning sessions and shall review and sign discharge summaries and records within 15 days of patient discharge. When patients are to be discharged to either another health care facility or a residential setting the attending physician shall ensure that the patient has been provided with a discharge plan which incorporates optimum utilization of community resources and post

discharge continuity of care and services.

*Statutory Authority G.S. 131E-79.*

#### **.5323 BRAIN INJURY EXTENDED CARE PROGRAM REQUIREMENTS**

(a) Brain injury long term care is an interdisciplinary, intensive maintenance program for patients who have incurred brain damage caused by external physical trauma and who have completed a primary course of rehabilitative treatment and have reach a point of no gain or progress for more than three consecutive months. Services are provided through a medically supervised interdisciplinary process as provided in Rule .5322 of this Section and are directed toward maintaining the individual at the optimal level of physical, cognitive and behavioral functioning. Following are the minimum requirements for specific services are necessary to maintaining the individual at optimum level:

- (1) Overall supervisory responsibility for brain injury long term care services shall be assigned to a registered nurse with one year experience in caring for brain injured patients;
- (2) Physical Therapy shall be provided by a physical therapist with a current North Carolina License. Occupational therapy shall be provided by an occupational therapist with a current North Carolina License. The services of a physical therapist and occupational therapist shall be combined to provide one full-time equivalent for each 20 patients. The services of a physical therapy aide and an occupational therapy aide with appropriate supervision shall be combined to provide one full-time equivalent for each 20 patients. A proportionate number of hours shall be provided for a census less than 20 patients;
- (3) Clinical nutrition services shall be provided by a qualified dietitian. The number of hours of clinical nutrition services on either a full time or part-time employment or contract basis shall meet the needs of the patients. Each patient's nutrition needs shall be reviewed at least monthly. Clinical nutrition services shall meet the requirements of Section .4700 of this Subchapter and shall include but not be limited to:

- (A) assessing the appropriateness of the ordered diet for conformance with each patient's physiological and pharmacological condition;
- (B) evaluating each patient's laboratory data in relation to nutritional status and hydration; and
- (C) applying technical knowledge of feeding tubes, pumps and equipment to each patient's specialized needs.
- (4) Clinical social work shall be provided by a social worker meeting the requirements of Rule .5319 of this Section;
- (5) Recreation therapy when required, shall be provided on either a full-time or part-time employment or contract basis by a clinician eligible for certification as a therapeutic recreation specialist by the State Board of Therapeutic Recreation Certification. Therapeutic recreation services shall meet the needs of the patients. In the event that a qualified specialist is not locally available, alternate treatment modalities shall be developed by the occupational therapist and reviewed by the attending physician. The program designed shall meet the needs of this specialized population and must be administered in accordance with Rule .5318 of this Section;
- (6) Speech therapy, when required, shall be provided by a clinician with a current license in speech pathology issued by the State Board of Audiology and Speech pathology; and
- (7) Respiratory therapy, when required, shall be provided and supervised by a respiratory therapist currently registered by the National Board for Respiratory Care.

(b) Each patient's program shall be governed by a interdisciplinary treatment plan incorporating and expanding upon the health plan required under Rules .5307 and .5308 of this Section. The plan is to be initiated on the first day of admission. Upon completion of baseline data development and an integrated interdisciplinary assessment, the initial treatment plan is to be expanded and finalized within 14 days of admission. The treatment plan shall be reviewed at least monthly through an interdisciplinary process and revised as appropriate. In executing the treatment plan the interdisciplinary team shall be the major decision-

making body and shall determine the goals, process and time frames for accomplishment of each patient's program. Disciplines to be represented on the team shall be medicine, nursing, clinical pharmacy and all other disciplines directly involved in the patient's treatment or treatment plan.

(c) Each patient's overall program shall be assigned to an individually designated case manager. The case manager acts as the coordinator for assigned patients. Any professional staff member involved in the patient's care may be assigned this responsibility for one or more patients. Professional staff may divide this responsibility for all patients on the unit in the best manner to meet all patients' needs for a coordinated interdisciplinary approach to care. The case manager shall be responsible for:

- (1) coordinating the development, implementation and periodic review of the patient's treatment plan;
- (2) preparing a monthly summary of the patient's progress;
- (3) cultivating the patient's participation in the program;
- (4) general supervision of the patient during the course of treatment;
- (5) evaluating appropriateness of the treatment plan in relation to the attainment of stated goals; and
- (6) assuring that discharge decisions and arrangements for post discharge follow-up are properly made.

(d) For each 20 patients or fraction thereof, dedicated treatment facilities and equipment shall be provided as follows:

- (1) a combined therapy space equal to or exceeding 600 square feet, adequately equipped and arranged to support each of the therapies;
- (2) access to one full reclining wheelchair per patient;
- (3) special physical therapy and occupational therapy equipment for use in fabricating positioning devices for beds and wheelchairs including splints, casts, cushions, wedges, and bolster; and
- (4) there shall be roll-in bath facilities with a dressing area available to all patients which shall afford maximum privacy to the patient.

*Statutory Authority G.S. 131E-79.*



**.5324 SPECIAL NURSING REQUIREMENTS  
BRAIN INJURY LONG TERM CARE**

Direct care nursing personnel staffing ratios (NH/PD) established in Rule .5310 of this Section shall not be applied to nursing services for patients who require brain injury long term care, due to their more intensive maintenance and nursing needs. The minimum direct care nursing staff shall be 5.5 hrs. per patient day allocated as the facility chooses to appropriately meet the patient needs. It is also required, that regardless of how low the patient census, the direct care nursing staff shall not fall below a registered nurse and a nurse aide I at any time during a 24 hour period.

*Statutory Authority G.S. 131E-79.*

**.5325 VENTILATOR DEPENDENCE**

Hospital nursing facilities or units having patients requiring the use of ventilators for more than eight hours a day must meet the following requirements:

- (1) respiratory therapy shall be provided and supervised by a respiratory therapist currently registered by the National Board for Respiratory Care. The respiratory therapist shall:
  - (a) make, as a minimum, weekly on-site assessments of each patient receiving ventilator support with corresponding progress notes;
  - (b) be on-call 24 hours daily; and
  - (c) assist the pulmonologist and nursing staff in establishing ventilator policies and procedures, including emergency policies and procedures; and
- (2) direct nursing care staffing shall be in accordance with Rule .5324 of this Section.

*Statutory Authority G.S. 131E-79.*

**.5326 PHYSICIAN SERVICES FOR  
VENTILATOR DEPENDENT  
PATIENTS**

Hospitals with nursing facility beds with ventilator dependent care patients shall contract with a physician who is licensed to practice in North Carolina and who has specialized training in pulmonary medicine. This physician shall be responsible for respiratory services and shall:

- (1) establish, with the respiratory therapist and nursing staff, appropriate ventilator policies and procedures, including emergency procedures;
- (2) assess each ventilator patient's status at

least monthly with corresponding progress notes;

- (3) be available on an emergency basis; and
- (4) participate in individual patient case planning.

*Statutory Authority G.S. 131E-79.*

**.5327 EMERGENCY ELECTRICAL  
SERVICE**

(a) A minimum of one dedicated emergency branch circuit per bed is required for ventilator dependent patients in addition to the normal system receptacle at each bed location required by the National Electrical Code. This emergency circuit shall be provided with a minimum of two duplex receptacles identified for emergency use. Additional emergency branch circuits/receptacles shall be provided where the electrical life support needs of the patient exceed the minimum requirements stated above. Each emergency circuit serving ventilator dependent patients shall be fed from the automatically transferred critical branch of the essential electrical system. This paragraph shall apply to both new and existing facilities.

(b) Heating equipment provided for ventilator dependent patient bedrooms shall be connected to the critical branch of the essential electrical system and arranged for delayed automatic or manual connection to the emergency power source if the heating equipment depends upon electricity for proper operation. This paragraph shall apply to both new and existing facilities.

*Statutory Authority G.S. 131E-79.*

**SECTION .5400 - SPECIALLY  
DESIGNATED UNITS**

**.5401 ADMISSIONS TO THE HIV  
DESIGNATED UNIT**

If a facility declines admission to a patient known to have Human Immunodeficiency Virus disease the reasons for the denial shall be documented.

*Statutory Authority G.S. 131E-79.*

**.5402 DISCHARGE OF PATIENTS FROM  
THE HIV DESIGNATED UNIT**

(a) A record shall be maintained of all discharges of patients indicating the reasons for discharge, the physician's order for or other authorization for discharge, and the condition of the patient at the time of discharge.

(b) A patient known to have Human

Immunodeficiency Virus disease may not be discharged solely on the basis of the diagnosis of Human Immunodeficiency Virus disease except as authorized by the provisions of G.S. 131E-117 (15) or other provisions of the N. C. General Statutes or rules promulgated thereunder or provisions of applicable federal laws and regulations.

*Statutory Authority G.S. 131E-79.*

#### **.5403 HIV DESIGNATED UNIT POLICIES AND PROCEDURES**

(a) In units dedicated to the treatment of patients with Human Immunodeficiency Virus disease, policies and procedures specific to the specialized needs of the patients served shall be developed. At a minimum they shall include staff training and education, and the availability of consultation by a physician with specialized education or knowledge in the management of Human Immunodeficiency Virus disease.

(b) Policies and procedures for infection control shall be in conformance with 29 CFR 1910 Occupational Safety and Health Standards which is incorporated by reference including subsequent amendments. Emphasis shall be placed on compliance with 29 CFR 1910-1030 (Bloodborne Pathogens). Copies of Title 29 Part 1910 may be purchased from the Superintendent of Documents, W.S. Government Printing Office, Washington, D.S. 20402 for thirty eight dollars (\$38.00) and may be purchased with a credit card by a direct telephone call to the G.P.O. at (202) 783-3238. Infection control shall also be in compliance with the Center of Disease Control Guidelines as published by the U.S. Department of Health and Human Services, Public Health Service which is incorporated by reference including subsequent amendments. Copies may be purchased from the National Technical Information Service, U.S. Department of Commerce, 5285 Port Royal Road, Springfield, Virginia, 22161 for fifteen dollars and ninety-five cents (\$15.95).

*Statutory Authority G.S. 131E-79.*

#### **.5404 PHYSICIAN SERVICES IN A HIV DESIGNATED UNIT**

In facilities with Human Immunodeficiency Virus designated unit, the facility shall insure that attending physicians have documented, pre-arranged access, either in person or by telephone, to a physician with specialized education or knowledge in the management of Human

Immunodeficiency Virus disease.

*Statutory Authority G.S. 131E-79.*

#### **.5405 SPECIAL NURSING REQUIREMENTS FOR A HIV DESIGNATED UNIT**

(a) Facilities with a Human Immunodeficiency Virus designated unit shall have a registered nurse with specialized education or knowledge in the care of Human Immunodeficiency Virus disease.

(b) Nursing personnel assigned to the Human Immunodeficiency Virus unit shall be regularly assigned to the unit. Rotations are acceptable to alleviate staff burnout or staffing emergencies.

*Statutory Authority G.S. 131E-79.*

#### **.5406 SPECIALIZED STAFF EDUCATION FOR THE HIV DESIGNATED UNIT**

For facilities with a Human Immunodeficiency Virus designated unit an organized, documented program of education specific to the care of patients infected with the HIV shall be provided and include at a minimum:

- (1) Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome disease processes;
- (2) transmission modes, causes, and prevention of Human Immunodeficiency Virus;
- (3) treatment of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome;
- (4) psycho-socio-economic needs of the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome patients;
- (5) in addition to the general hospital orientation to Occupational Safety and Health Administration guidelines for universal precautions, orientation to infection control specific to Human Immunodeficiency Virus disease must be provided upon employment or permanent assignment to the unit; Copies of Title 29 Part 1910 may be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 for thirty eight dollars (\$38.00) and may be purchased with a credit card by a direct telephone call to the G.P.O. at (202) 783-3238;
- (6) policies and procedures specific to the Human Immunodeficiency Virus designated unit; and



- (7) annual continuing education in infection control.

Statutory Authority G.S. 131E-79.

#### **.5407 USE OF INVESTIGATIONAL DRUGS ON THE HIV DESIGNATED UNIT**

(a) The supervision and monitoring for the administration of investigational drugs is the responsibility of the pharmacist and a registered nurse, acting pursuant to the orders of a physician. Responsibilities shall include, but not be limited to, the following:

- (1) to assure the provision of written guidelines for any investigational drug or study are provided; and
- (2) training and determination of staff's abilities regarding administration of drugs, policies and procedures and regulations.

(b) The pharmacist or physician dispensing the investigational drug is to provide the facility with information regarding at least the following:

- (1) a copy of the investigational therapy protocol, including drug information;
- (2) a copy of the patient's informed consent to participate in study;
- (3) drug storage;
- (4) handling of drug;
- (5) any specific drug preparation and administration instruction; and
- (6) specific details for drug accountability, resupply and return of unused drugs.

(c) Labeling of investigational drugs shall be in accordance with written guidelines of protocol and State and federal requirements regarding such drugs. Prescription labels for investigational drugs are to be distinguishable from other labels by an appropriate legend, "Investigational Drug" or "For Investigational Use Only".

Statutory Authority G.S. 131E-79.

#### **.5408 SOCIAL WORK SERVICES IN A HIV DESIGNATED UNIT**

The facility shall provide either by direct employment or by contract for social work services to include assistance to the patient in identification of supportive resources, financial services and assistance with discharge and transfer arrangements. The social worker shall provide or arrange for the provision of spiritual, pastoral and grief counseling for patients and staff where appropriate. Support services shall be provided to patient families and significant others. Where

necessary, coordination with treatment services for substance abuse, legal services and other community resources shall be identified.

Statutory Authority G.S. 131E-79.

### **SECTION .5500 - COMPREHENSIVE INPATIENT REHABILITATION**

#### **.5501 DEFINITIONS**

The following definitions shall apply to inpatient rehabilitation facilities or units only:

- (1) "Case management" means the coordination of services, for a given patient, between disciplines so that the patient may reach optimal rehabilitation through the judicious use of resources.
- (2) "Comprehensive, inpatient rehabilitation program" means a program for the treatment of persons with functional limitations or chronic disabling conditions who have the potential to achieve a significant improvement in activities of daily living. A comprehensive, rehabilitation program utilize a coordinated and integrated, interdisciplinary approach, directed by a physician, to assess patient needs and to provide treatment and evaluation of physical, psycho-social and cognitive deficits.
- (3) "Inpatient rehabilitation facility or unit" means a free-standing facility or a unit (unit pertains to contiguous dedicated beds and spaces) within an existing licensed health service facility approved in accordance with G.S. 131E, Article 9 to establish inpatient, rehabilitation beds and to provide a comprehensive, inpatient rehabilitation program.
- (4) "Medical consultations" means consultations which the rehabilitation physician or the attending physician determine are necessary to meet the acute medical needs of the patient and do not include routine medical needs.
- (5) "Occupational therapist" means any individual licensed in the State of North Carolina as an occupational therapist in accordance with the provisions of G.S. 90, Article 18D.
- (6) "Occupational therapist assistant" means any individual licensed in the State of North Carolina as an occupational therapist assistant in accordance with the

- provisions of G.S. 90, Article 18D.
- (7) "Psychologist" means a person licensed as a practicing psychologist in accordance with G.S. 90, Article 18A.
  - (8) "Physiatrist" means a licensed physician who has completed a physical medicine and rehabilitation residency training program approved by the Accrediting Council of Graduate Medical Education or the American Osteopathic Association.
  - (9) "Physical therapist" means any person licensed in the State of North Carolina as a physical therapist in accordance with the provisions of G.S. 90, Article 18B.
  - (10) "Physical therapist assistant" means any person licensed in the State of North Carolina as a physical therapist assistant in accordance with the provisions of G. S. 90-270.24, Article 18B.
  - (11) "Recreational therapist" means a person certified by the State of North Carolina Therapeutic Recreational Certification Board.
  - (12) "Rehabilitation nurse" means a registered nurse licensed in North Carolina, with training, either academic or on-the-job, in physical rehabilitation nursing and at least one year experience in physical rehabilitation nursing.
  - (13) "Rehabilitation aide" means an unlicensed assistant who works under the supervision of a registered nurse, licensed physical therapist or occupational therapist in accordance with the appropriate occupational licensure laws governing his or her supervisor and consistent with staffing requirements as set forth in Rule .5508 of this Section. The rehabilitation aide shall be listed on the North Carolina Nurse Aide Registry and have received additional staff training as listed in Rule .5509 of this Section.
  - (14) "Rehabilitation physician" means a physiatrist or a physician who is qualified, based on education, training and experience regardless of specialty, of providing medical care to rehabilitation patients.
  - (15) "Social worker" means a person certified by the North Carolina Certification Board for Social Work in accordance with G.S. 90B-3.
  - (16) "Speech and language pathologist" means any person licensed in the State of North Carolina as a speech and language

pathologist in accordance with the provisions of G.S. 90, Article 22.

Statutory Authority G.S. 131E-79.

#### .5502 PHYSICIAN REQUIREMENTS FOR INPATIENT REHABILITATION FACILITIES OR UNITS

(a) In a rehabilitation facility or unit, a rehabilitation physician shall participate in the provision and management of rehabilitation services and in the provision of medical services.

(b) In a rehabilitation facility or unit, a rehabilitation physician shall be responsible for a patient's interdisciplinary treatment plan. Each patient's interdisciplinary treatment plan shall be developed and implemented under the supervision of the physician.

(c) The rehabilitation physician shall participate in the preliminary assessment within 48 hours of admission, prepare a plan of care and direct the necessary frequency of contact based on the medical and rehabilitation needs of the patient. The frequency shall be appropriate to justify the need for comprehensive inpatient rehabilitation care.

(d) An inpatient rehabilitation facility or unit's contract or agreements with a rehabilitation physician shall require that the rehabilitation physician shall participate in individual case conferences or care planning sessions and shall review and sign discharge summaries and records. When patients are to be discharged to another health care facility, the discharging facility shall ensure that the patient has been provided with a discharge plan which incorporates post discharge continuity of care and services. When patients are to be discharged to a residential setting, the facility shall ensure that the patient has been provided with a discharge plan that incorporates the utilization of community resources when available and when included in the patient's plan of care.

(e) The intensity of physician medical services and the frequency of regular contacts for medical care for the patient shall be determined by the patient's pathophysiologic needs.

(f) Where the attending physician of a patient in an inpatient rehabilitation facility or unit orders medical consultations for the patient, such consultations should be provided by qualified physicians within 48 hours of the physician's order. In order to achieve this result, the contracts or agreements between inpatient rehabilitation facilities or units and medical consultants shall require that such consultants render the requested



medical consultation within 48 hours.

(g) An inpatient rehabilitation facility or unit shall have a written procedure for setting the qualifications of the physicians, rendering physical rehabilitation services in the facility or unit.

*Statutory Authority G.S. 131E-79.*

### **.5503 ADMISSION CRITERIA FOR INPATIENT REHABILITATION FACILITIES OR UNITS**

(a) The facility shall have written criteria for admission to the inpatient rehabilitation facility or unit. A description of programs or services for screening the suitability of a given patient for placement shall be available to staff and referral sources.

(b) For patients found unsuitable for admission to the inpatient rehabilitation facility or unit, there shall be documentation of the reasons.

(c) Within 48 hours of admission, a preliminary assessment shall be completed by members of the interdisciplinary team to insure the appropriateness of placement and to identify the immediate needs of the patients.

(d) Patients admitted to an inpatient rehabilitation facility or unit must be able to tolerate a minimum of three hours of rehabilitation therapy, five days a week, including at least two of the following rehabilitation services: physical therapy, occupational therapy or speech therapy.

(e) Patients admitted to an inpatient rehabilitation facility or unit must be medically stable, have a prognosis indicating a progressively improved medical condition and have the potential for increased independence.

*Statutory Authority G.S. 131E-79.*

### **.5504 COMPREHENSIVE INPATIENT REHABILITATION EVALUATION**

(a) A comprehensive, inpatient rehabilitation evaluation is required for each patient admitted to an inpatient rehabilitation facility or unit. At a minimum this evaluation shall include the reason for referral, a summary of the patient's clinical condition, functional strengths and limitations, and indications for specific services. This evaluation shall be completed within three days of admission.

(b) Each patient shall be evaluated by the interdisciplinary team to determine the need for any of the following services: medical, dietary, occupational therapy, physical therapy, prosthetics and orthotics, psychological assessment and therapy, therapeutic recreation, rehabilitation

medicine, rehabilitation nursing, therapeutic counseling or social work, vocational rehabilitation evaluation and speech-language pathology.

*Statutory Authority G.S. 131E-79.*

### **.5505 COMPREHENSIVE INPATIENT REHABILITATION INTER - DISCIPLINARY TREAT/PLAN**

(a) The interdisciplinary treatment team shall develop an individual treatment plan for each patient within seven days after admission. The plan shall include evaluation findings and information about the following:

- (1) prior level of function;
- (2) current functional limitations;
- (3) specific service needs;
- (4) treatment, supports and adaptations to be provided;
- (5) specified treatment goals;
- (6) disciplines responsible for implementation of separate parts of the plan; and
- (7) anticipated time frames for the accomplishment of specified long-term and short-term goals.

(b) The treatment plan shall be reviewed by the interdisciplinary team at least every other week. All members of the interdisciplinary team, or a representative of the discipline, shall attend each meeting. Documentation of each review shall include progress toward defined goals and identification of any changes in the treatment plan.

(c) The treatment plan shall include provisions for all of the services identified as needed for the patient in the comprehensive, inpatient rehabilitation evaluation completed in accordance with Rule .2023 of this Subchapter.

(d) Each patient shall have a designated case manager who is responsible for the coordination of the patient's individualized treatment plan. The case manager is responsible for promoting the program's responsiveness to the needs of the patient and shall participate in all team conferences concerning the patient's progress toward the accomplishment of specified goals. Any of the professional staff involved in the patient's care may be the designated case manager for one or more cases, or the director of nursing or social worker may accept the coordination responsibility for the patients.

*Statutory Authority G.S. 131E-79.*

### **.5506 DISCHARGE CRITERIA FOR**

# INPATIENT REHABILITATION FACILITIES OR UNITS

(a) Discharge planning shall be an integral part of the patient's treatment plan and shall begin upon admission to the facility. After established goals have been reached, or a determination has been made that care in a less intensive setting would be appropriate, or that further progress is unlikely, the patient shall be discharged to an appropriate setting. Other reasons for discharge may include an inability or unwillingness of the patient or his 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 and referral sources in discharge planning.

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

(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 to the receiving facility 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 and activities and procedures used by the patient to maintain and improve functioning.

*Statutory Authority G.S. 131E-79.*

## .5507 COMPREHENSIVE REHABILITATION PERSONNEL ADMINISTRATION

(a) The facility shall have qualified staff members, consultants and contract personnel to provide services to the patients admitted to the inpatient rehabilitation facility or unit.

(b) Personnel shall be employed or provided by contractual agreement in sufficient types and numbers to meet the needs of all patients admitted for comprehensive rehabilitation.

(c) Written agreements shall be maintained by the facility when services are provided by contract on an ongoing basis.

*Statutory Authority G.S. 131E-79.*

## .5508 COMPREHENSIVE INPATIENT REHABILITATION PROGRAM STAFFING REQUIREMENTS

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

- (1) the inpatient rehabilitation facility or unit shall be supervised by a rehabilitation nurse. The facility shall identify the nursing skills necessary to meet the needs of the rehabilitation patients in the unit and assign staff qualified to meet those needs;
- (2) the minimum nursing hours per patient in the rehabilitation unit shall be 5.5 nursing hours per patient day. At no time shall direct care nursing staff be less than two full-time equivalents, one of which must be a registered nurse;
- (3) the inpatient rehabilitation unit shall employ or provide by contractual agreement sufficient therapist, licensed in North Carolina, 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 licensed or certified and shall be supervised on-site by licensed physical therapists or licensed occupational therapists;
- (5) rehabilitation aides shall have documented training appropriate to the activities to be performed and the occupational licensure laws of his or her supervisor. The overall responsibility for the on-going supervision and evaluation of the rehabilitation aide remains with the registered nurse as identified in Subparagraph (a)(1) of this Rule. Supervision by the licensed 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 hours of service by the rehabilitation aide are counted toward the required nursing hours when the aide is working under the supervision of the registered 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 services shall not be duly counted for both services. Hours of service by rehabilitation aides in performing nurse-
- (6)



aide duties in areas of the facility other than the rehabilitation unit shall not be counted toward the 5.5 hour minimum nursing requirements 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.

*Statutory Authority G.S. 131E-79.*

#### **.5509 STAFF TRAINING FOR INPATIENT REHABILITATION FACILITIES OR UNIT**

Prior to the provision of care, all rehabilitation personnel, excluding physicians, assigned to the rehabilitation unit shall be provided training or shall provide documentation of training, that includes at a minimum the following:

- (1) active and passive range of motion;
- (2) assistance with ambulation;
- (3) transfers;
- (4) maximizing functional independence;
- (5) the psycho-social needs of the rehabilitation patient;
- (6) the increased safety risks of rehabilitation training (including falls and the use of restraints);
- (7) proper body mechanics;
- (8) nutrition, including dysphagia and restorative eating;
- (9) communication with the aphasic and hearing impaired patient;
- (10) behavior modification;
- (11) bowel and bladder training; and
- (12) skin care.

*Statutory Authority G.S. 131E-79.*

#### **.5510 EQUIPMENT REQUIREMENTS/ COMPREHENSIVE INPATIENT REHABILITATION PROGRAMS**

(a) The facility shall provide each discipline with the necessary equipment and treatment methods to achieve the short and long-term goals specified in the comprehensive inpatient rehabilitation interdisciplinary treatment plans for patients admitted to these facilities or units.

(b) Each patient's needs for a standard wheelchair or a specially designed wheelchair or additional devices to allow safe and independent mobility within the facility shall be met.

(c) Special physical therapy and occupational therapy equipment for use in fabricating positioning

devices for beds and wheelchairs shall be provided including splints, casts, cushions, wedges and bolsters.

(d) Physical therapy devices, including a mat, table, parallel bars, and sliding boards, and special adaptive bathroom equipment shall be provided.

*Statutory Authority G.S. 131E-79.*

#### **.5511 PHYSICAL FACILITY REQUIREMENTS/INPATIENT REHABILITATION FACILITIES OR UNIT**

(a) The inpatient rehabilitation facility or unit shall be in a designated area and shall be used for the specific purpose of providing a comprehensive, inpatient rehabilitation program.

(b) The floor area of a single bedroom shall be sufficient for the patient or the staff to easily transfer the patient from the bed to a wheelchair and to maneuver a 180 degree turn with a wheelchair between beds.

(c) The floor area of a multi-bed bedroom shall be sufficient for the patient or the staff to easily transfer the patient from the bed to a wheelchair and to maneuver a 180 degree turn with a wheelchair between beds.

(d) Each patient room shall meet the following requirements:

- (1) maximum room capacity of no more than four patients;
- (2) operable windows;
- (3) a nurse call system designed to meet the special needs of rehabilitation patients;
- (4) in single and two-bed rooms with private toilet room, the lavatory may be located in the toilet room;
- (5) a wardrobe or closet for each patient which is wheelchair accessible and arranged to allow the patient to access the contents;
- (6) a chest of drawers or built-in drawer storage with mirror above, which is wheelchair accessible; and
- (7) a bedside table for toilet articles and personal belongings.

(e) Space for emergency equipment such as resuscitation carts shall be provided and shall be under direct control of the nursing staff, in proximity to the nurse's station and out of traffic.

(f) Patients' bathing facilities shall meet the following specifications:

- (1) there shall be at least one shower stall or one bathtub for each 15 beds, if not available in individual rooms. Each tub

or shower shall be in an individual room or privacy enclosure which provides space for the private use of the bathing fixture, for drying and dressing and for a wheelchair and an assisting attendant.

- (2) showers in central bathing facilities shall be at least five foot square without curbs and designed to permit use by a wheelchair patient.
- (3) at least one five-foot-by-seven-foot shower shall be provided which can accommodate a stretcher and an assisting attendant.

(g) Patients' toilet rooms and lavatories shall meet the following specifications:

- (1) the size of toilets shall permit a wheelchair, a staff person and appropriate wheel-to-water closet transfers.
- (2) Lavatories serving patients shall:
  - (A) allow wheelchairs to extend under the lavatory; and
  - (B) have water supply spout mounted so that its discharge point is a minimum of five inches above the rim of the fixture; and
- (3) Lavatories used by patients and by staff shall be equipped with blade-operated supply valves.

(h) The space provided for physical therapy, occupational therapy and speech therapy by all inpatient rehabilitation facilities or units may be shared but shall, at a minimum, include:

- (1) office space for staff;
- (2) office space for speech therapy evaluation and treatment;
- (3) waiting space;
- (4) training bathroom which includes toilet, lavatory and bathtub;
- (5) gymnasium or exercise area;
- (6) work area such as tables or counters suitable for wheelchair access;
- (7) treatment areas with available privacy curtains or screens;
- (8) an activities of daily living training kitchen with sink, cooking top (secured when not supervised by staff), refrigerator and counter surface for meal preparation;
- (9) storage for clean linens, supplies and equipment;
- (10) janitor's closet accessible to the therapy area with floor receptor or service sink and storage space for housekeeping

supplies and equipment, one closet or space may serve more than one area of the inpatient rehabilitation facility or unit; and

(11) hand washing facilities.

(i) For social work and psychological services the following shall be provided:

- (1) work space for technician;
- (2) space for evaluation and counseling for all family members; and
- (3) workspace for testing, evaluation and counseling.

(j) If prosthetics and orthotics services are provided, the following space shall be made available as necessary:

- (1) work space for technician; and
- (2) space for evaluation and fittings (with provisions for privacy).

(k) If vocational therapy services are provided, the following space shall be made available as necessary:

- (1) office space for staff;
- (2) workspace for vocational services activities such as prevocational and vocational evaluation;
- (3) training space;
- (4) storage for equipment; and
- (5) counseling and placement space.

(l) Recreational therapy space requirements shall include the following:

- (1) activities space;
- (2) storage for equipment and supplies;
- (3) office space for staff; and
- (4) access to male and female toilets.

(m) The following space shall be provided for patient's dining, recreation and day areas:

- (1) sufficient room for wheelchair movement and wheelchair dining seating;
- (2) if food service is cafeteria type, adequate width for wheelchair maneuvers, queue space within the dining area (and not in a corridor) and a serving counter low enough to view food;
- (3) total space for inpatients, a minimum of 25 square feet per bed;
- (4) for outpatients participating in a day program or partial day program, 20 square feet when dining is a part of the program and 10 square feet when dining is not a part of the program; and
- (5) storage for recreational equipment and supplies, tables and chairs.
- (6) the patient dining, recreation and day



area spaces shall be provided with windows that have glazing of an area not less than eight percent of the floor area of the space. At least one half of the required window area must be operable.

(n) A laundry shall be available and accessible for patients.

*Statutory Authority G.S. 131E-79.*

#### **.5512 ADDITIONAL REQUIREMENTS FOR TRAUMATIC BRAIN INJURY PATIENTS**

Inpatient rehabilitation facilities providing services to persons with traumatic brain injuries shall meet the requirements in this rule in addition to those identified in this Section.

- (1) Direct-care nursing personnel staffing ratios established in Rule .5508 of this Section shall not be applied to nursing services for traumatic brain injury patients in the inpatient, rehabilitation facility or unit. The minimum nursing hours per traumatic brain injury patient in the unit shall be 6.5 nursing hours per patient day. At no time shall direct care nursing staff be less than two full-time equivalents, one of which shall be a registered nurse.
- (2) The inpatient rehabilitation facility or unit shall employ or provide by contractual agreements physical, occupational or speech therapists in order to provide a minimum of 4.5 hours of specific or combined rehabilitation therapy services per traumatic brain injury patient day.
- (3) The facility shall provide special facility or equipment needs for patients with traumatic brain injury, including a quiet room for therapy, specially designed wheelchairs and standing tables.
- (4) The medical director, appointed by the governing body, of an inpatient traumatic brain injury program shall have two years management in a brain injury program, one of which may be in a clinical fellowship program and board eligibility or certification in the medical specialty of the physician's training.
- (5) The facility shall provide the consulting services of a neuropsychologist.
- (6) The facility shall provide continuing education in the care and treatment of brain injury patients for all staff.

- (7) The size of the brain injury program shall be adequate to support a comprehensive, dedicated ongoing brain injury program.

*Statutory Authority G.S. 131E-79.*

#### **.5513 ADDITIONAL REQUIREMENTS FOR SPINAL CORD INJURY PATIENTS**

Inpatient rehabilitation facilities providing services to persons with spinal cord injuries shall meet the requirements in this rule in addition to those identified in this Section.

- (1) Direct-care nursing personnel staffing ratios established in Rule .5508 of this Section shall not be applied to nursing services for spinal cord injury patients in the inpatient, rehabilitation facility or unit. The minimum nursing hours per spinal cord injury patient in the unit shall be 6.0 nursing hours per patient day. At no time shall direct care nursing staff be less than two full-time equivalents, one of which shall be a registered nurse.
- (2) The inpatient rehabilitation facility or unit shall employ or provide by contractual agreements physical, occupational or speech therapists in order to provide a minimum of 4.0 hours of specific or combined rehabilitation therapy services per spinal cord injury patient day.
- (3) The facility shall provide special facility or special equipment for the patient with spinal cord injury, including specially designed wheelchairs, tilt tables and standing tables.
- (4) The medical director, appointed by the governing body, of an inpatient spinal cord injury program shall have either two years experience in the medical care of persons with spinal cord injuries or six month's minimum in a spinal cord injury fellowship.
- (5) The facility shall provide continuing education in the care and treatment of spinal cord injury patients for all staff.
- (6) The facility shall provide specific staff training and education in the care and treatment of spinal cord injury.
- (7) The size of the spinal cord injury program shall be adequate to support a comprehensive, dedicated ongoing spinal cord injury program.

*Statutory Authority G.S. 131E-79.*

**.5514 DEEMED STATUS FOR INPATIENT REHABILITATION FACILITIES OR UNIT**

(a) If an inpatient rehabilitation facility or unit with a comprehensive inpatient rehabilitation program is surveyed and accredited by the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF) and has been approved by the Department in accordance with Article 9 Chapter 131E of the North Carolina General Statutes, the Division deems the facility to be in compliance with Rules .2020 through .2030 and .2033 of this Subchapter.

(b) Deemed status shall be provided only if the inpatient rehabilitation facility or unit provides copies of survey reports to the Division. The JCAHO report shall show that the facility or unit was surveyed for rehabilitation services. The CARF report shall show that the facility or unit was surveyed for comprehensive rehabilitation services. The facility or unit shall sign an agreement (Memorandum of Understanding) with the Division specifying these terms.

(c) The inpatient rehabilitation facility or unit shall be subject to inspections or complaint investigations by representatives of the Division at any time. If the facility or unit is found not to be in compliance with the rules listed in Paragraph (a) of this Rule, the facility shall submit a plan of correction and be subject to a follow-up visit to ensure compliance.

(d) If the inpatient rehabilitation facility or unit loses or does not renew its accreditation, the facility or unit shall notify the Division in writing within 30 days.

*Statutory Authority G.S. 131E-79.*

**SECTION 5600 - .5900 - RESERVED FOR FUTURE CODIFICATION**

**SECTION .6000 - PHYSICAL PLANT**

**.6001 LOCATION**

(a) The site of any facility shall be accessible to service vehicles, fire protection and emergency apparatus.

(b) The water supply system available to the site shall be tested to determine the mineral and salts content and their effect on the various water systems in the facility. When these tests indicate the facility will have problems in maintenance and upkeep, the facility shall provide a water treatment system.

*Statutory Authority G.S. 131E-79.*

**.6002 ROADS AND PARKING**

(a) Paved roads shall be provided within the property lines to provide access to the main entrance, emergency entrance, and to service entrances, including loading and unloading docks for delivery trucks.

(b) Facilities having an organized emergency services department shall have the emergency entrance well marked to facilitate entry from the public roads or streets serving the site.

(c) Paved walkways shall be provided for necessary pedestrian traffic.

(d) Off-street parking shall be made available for patients, staff, and visitors.

*Statutory Authority G.S. 131E-79.*

**SECTION .6100 - GENERAL REQUIREMENTS**

**.6101 GENERAL**

The design, construction, maintenance and operation of a facility shall be in accordance with those codes and standards listed in Rule .6102, LIST OF REFERENCED CODES AND STANDARDS of this Section, and codes, ordinances, and regulations enforced by city, county, or other state jurisdictions with the following requirements:

(1) Notify the Division when all construction or renovation has been completed, inspected and approved by the architect and engineer having responsibility, and the facility is ready for a final inspection. Prior to using the completed project, the facility shall receive from the Division, written approval for use. The approval shall be based on an on-site inspection by the Division or by documentation as may be required by the Division;

(2) In the absence of any requirements by other authorities having jurisdiction, develop a master fire and disaster plan with input from the local fire department and local emergency management agency to fit the needs of the facility. The plan shall require:

(a) Training of facility employees in the fire plan implementation, in the use of fire-fighting equipment, and in evacuation of patients and staff from areas in danger during an emergency condition;



- (b) Conducting of quarterly fire drills on each shift;
- (c) A written record of each drill shall be on file at the facility for at least three years;
- (d) The testing and evaluation of the emergency electrical system(s) once each year by simulating a utility power outage by opening of the main facility electrical breaker(s). Documentation of the testing and results shall be completed at the time of the test and retained by the facility for three years; and
- (e) Disaster planning to fit the specific needs of the facility's geographic location and disaster history, with at least one documented disaster drill conducted each year.

*Statutory Authority G.S. 131E-79.*

#### **.6102 LIST OF REFERENCED CODES AND STANDARDS**

The following codes and standards are adopted by reference including subsequent amendments. Copies of these publications can be obtained from the various organizations at the addresses listed:

- (1) The North Carolina State Building Code, current edition, all volumes including subsequent amendments. Copies of this code may be purchased from the N.C. Department of Insurance Engineering Division located at 410 North Boylan Avenue, Raleigh, NC 27603 at a cost of two hundred fifty dollars (\$250.00).
- (2) The National Fire Protection Association codes, current edition, all volumes including subsequent amendments. Copies of these codes and standards may be obtained from the National Fire Protection Association, 1 Batterymarch Park, PO Box 9101, Quincy, MA 02269-9101 at a cost of six hundred twenty-five dollars (\$625.00).
- (3) "Rules Governing the Sanitation of Hospitals, Nursing and Rest Homes, Sanitariums, Sanitoriums, and Educational and Other Institutions" of the N.C. Department of Environment, Health and Natural Resources, current edition including subsequent amendments. Copies of these rules may be obtained from the N.C. Department of Environment, Health and Natural

Resources, Division of Environmental Health, Environmental Health Services Section, 512 N. Salisbury Street, Raleigh, NC 27604-1148 at no cost.

- (4) American Society of Heating, Refrigerating & Air Conditioning Engineers, (ASHRAE) HVAC Systems and Equipment, current edition including subsequent amendments. Copies of this document may be obtained from the American Society of Heating, Refrigerating & Air Conditioning Engineers at United Engineer Center, 345 East 47th Street, New York, NY 10017 at a cost of one hundred nineteen dollars (\$119.00).
- (5) Rules and Statutes Governing the Licensure of Ambulatory Surgical Facilities, current edition including subsequent amendments. Copies of this document may be obtained from the N.C. Department of Human Resources, Division of Facility Services, Licensure Section, 701 Barbour Drive, Raleigh, NC 27603 at a cost of three dollars (\$3.00).
- (6) The Standards for Obstetric-Gynecologic Services, current edition including subsequent amendments. Copies of this standard may be obtained from The American College of Obstetricians and Gynecologists, 600 Maryland Avenue, SW, Suite 700 East, Washington, DC 20024-2588 at a cost of thirty five dollars (\$35.00).

*Statutory Authority G.S. 131E-79.*

#### **.6103 APPLICATION OF PHYSICAL PLANT REQUIREMENTS**

The physical plant requirements for each facility shall be applied as follows:

- (1) New construction shall comply with the requirements of Section .6000 of this Subchapter;
- (2) Existing buildings shall meet licensure and code requirements in effect at the time of construction, alteration, or modification;
- (3) New additions, alterations, modifications, and repairs shall meet the technical requirements of Section .6000 of this Subchapter, however, where strict conformance with current requirements would be impractical, the authority having jurisdiction may approve

alternative measures where the facility can demonstrate to the Division's satisfaction that the alternative measures do not reduce the safety or operating effectiveness of the facility;

- (4) Rules contained in Section .6000 of this Subchapter are minimum requirements and not intended to prohibit buildings, systems or operational conditions that exceed minimum requirements;
- (5) Equivalency: Alternate methods, procedures, design criteria, and functional variations from the physical plant requirements, because of extraordinary circumstances, new programs, or unusual conditions, may be approved by the authority having jurisdiction when the facility can effectively demonstrate to the Division's satisfaction, that the intent of the physical plant requirements are met and that the variation does not reduce the safety or operational effectiveness of the facility; and
- (6) Where rules, codes, or standards have any conflict, the most stringent requirement shall apply.

*Statutory Authority G.S. 131E-79.*

#### **.6104 ACCESS AND SAFETY**

Projects involving replacement, alterations of, and additions to existing facilities shall be planned and phased so that construction will minimize disruptions of essential facility operations. Facility access, exit ways, safety provisions, and building and life safety systems shall be maintained so that the health and safety of the occupants will not be jeopardized during construction. Additional safety and operating measures shall be planned and executed to compensate for hazards related to construction or renovation activities to maintain an equivalent degree of health, safety, and operational effectiveness to that required by rules, standards, and codes for a facility not under construction or renovation.

*Statutory Authority G.S. 131E-79.*

### **SECTION .6200 - CONSTRUCTION REQUIREMENTS**

#### **.6201 MEDICAL, SURGICAL AND POST-PARTUM CARE UNIT**

The following requirements shall apply to

licensed beds:

- (1) Each patient room shall meet the following requirements:
  - (a) Maximum room capacity shall be four patients;
  - (b) Minimum room areas exclusive of toilet rooms, closets, lockers, wardrobes, bathing room, or vestibules shall be 100 square feet in single bed rooms and 80 square feet per bed in multi-bed rooms;
  - (c) Provide a minimum of three feet of clear working space on three sides of each bed;
  - (d) A window which can be opened from the inside shall be provided. The window sill shall not be higher than three feet above the floor and shall be above grade;
  - (e) A nurses' calling station at each patient bed and toilet room shall be provided;
  - (f) At least one lavatory shall be provided in each patient room. In a single bedroom other than post-partum rooms, the lavatory may be omitted from the patient room when a lavatory is located in an adjoining toilet room which serves that room only;
  - (g) A toilet room containing a water closet and a lavatory shall be provided to serve no more than four beds or two patient rooms;
  - (h) A wardrobe, locker or closet shall be provided for each patient suitable for hanging garments as well as for storage of personal effects; and
  - (i) Provision shall be made for the visual privacy of each patient in multi-bed rooms.
- (2) The following service areas shall be located no further than 120 feet travel distance from each patient bedroom door:
  - (a) Nurses' station;
  - (b) Hand washing facilities located at the nurses' station;
  - (c) Charting facilities;
  - (d) A clean workroom or a clean holding room for storage and distribution of clean supply materials. The clean workroom shall contain a work counter and hand washing and storage facilities. A clean holding room shall be similar to a clean workroom except it shall be a part of a clean supply system and the work counter and hand washing facilities may be omitted;



- (e) A soiled workroom or a soiled holding room as a part of a system for the collection and disposal of soiled materials. The soiled workroom shall contain a clinical sink or other suitable flushing device, sink equipped for hand washing, a work counter, a waste receptacle, and a linen receptacle. A soiled holding room shall be similar to the soiled workroom except that it shall be a part of the soiled disposal system. The waste receptacle, clinical sink and work counter may be omitted;
- (f) A drug distribution station that meets the current minimum requirements of governing state and federal agencies regulating controlled substances including a lavatory;
- (g) A clean linen storage closet. This may be a designated area within the clean workroom. If a closed cart system is used, storage may be in a controlled alcove out of corridor traffic;
- (h) A nourishment station that contains a lavatory, equipment for serving nourishment between meals, refrigerator and storage facilities. Ice dispensing facilities for patient service and treatment shall be of a type that will not require use of scoops;
- (i) Storage of equipment including emergency equipment shall be provided to insure corridors are kept clear; and
- (j) Parking for stretchers and wheelchairs located out of corridor widths.
- (3) The following service areas shall be provided for each nursing unit:
  - (a) Nurses office;
  - (b) Closets or compartments for the safekeeping of coats and personal effects of staff;
  - (c) Conference room;
  - (d) Room for examination and treatment of patients. This room may be omitted if all patient rooms are single-bed rooms. This room shall have a minimum floor area of 100 square feet, excluding space for vestibule less than eight feet wide, toilet, closets and work counters (whether fixed or movable). The minimum room dimension shall be 10 feet. The room shall contain a lavatory, a work counter, storage facilities and a desk, counter or shelf space for writing;
- (e) Lounge and toilet room for staff;
- (f) Janitors' closet. This room shall contain a floor receptor or service sink and storage space for housekeeping supplies and equipment; and
- (g) Individually enclosed bathtubs or individually enclosed showers at the rate of one for each 12 beds or fraction thereof which are not otherwise served by bathing facilities within the patient rooms.
- (4) Each facility shall make provisions for at least one room for patients needing close supervision including provisions to minimize the chance of a patients' hiding, escape, injury or suicide.
- (5) Isolation Rooms. Rooms for patients requiring isolation for infection control purposes shall be provided at the ratio of one isolation room for each 30 acute care licensed beds or major fraction thereof. These may be located within each nursing unit or placed together in a separate unit. Each isolation room shall be a single-bed room and shall conform to the requirements of Paragraph (a) of this Rule except as follows:
  - (a) A private toilet room containing a water closet and a bath or shower for the exclusive use of the patient which can be entered directly from the patient bed area without passing through the vestibule or anteroom shall be provided;
  - (b) A lavatory for the exclusive use of the patient shall be provided. It may be located in the patient room or in the private toilet room;
  - (c) Entrance from the corridor shall be through a closed anteroom which contains facilities to assist staff personnel in maintaining aseptic conditions. The anteroom shall contain a lavatory equipped for hand washing, storage for clean and soiled materials, and gowning facilities; and
  - (d) A view window in the door for nursing observation of the patient from the anteroom shall be provided.
- (6) Provision shall be made for delivery of medications to patients. All medications and related items shall be stored in compliance with current Federal and State laws and rules and made accessible only to authorized personnel. A

medication preparation area, alcove, room or other designated area shall be under the direct supervision of the nursing staff when not in use. It shall contain at least a work counter, lavatory, medication-only refrigerator and designated locked area for controlled substances; if mobile systems are used, storage in corridors is prohibited except when in use by the nursing staff.

*Statutory Authority G.S. 131E-79.*

## **.6202 SPECIAL CARE UNIT**

(a) Each patient room shall meet the following requirements:

- (1) Clearance between beds in multi-bed rooms shall be not less than 7 feet with provision for visual privacy of patients. Each patient bed space shall have a minimum of 130 square feet with a minimum dimension of 11 feet;
- (2) One single isolation bedroom shall be provided for each 12 special care beds or fraction thereof;
- (3) Glazing in all viewing panels in partitions and doors shall be safety glass, wire glass, or fire rated glass;
- (4) A lavatory shall be provided in each patient room. In multi-bed rooms, lavatories shall be provided within 10 feet of each bed;
- (5) A nurse call system is required except in neonatal units;
- (6) Each single-bed cubicle or room shall have a window to the outdoors. In the case of ward-type patient bed areas of two or more patients where cubicle privacy curtains are used, at least one window shall be provided for every two beds. Windows shall be positioned to provide a maximum distance of 18 feet between the normal head position of each patient and a window. Window sills shall not exceed five feet above the floor; and
- (7) Toilet facilities provided for each special care unit shall be accessible from within the unit. Portable toilets may be used within the patient room. Storage and service of portable toilets shall be provided, if used. Fixed toilets shall have sufficient clearance to facilitate use by patients needing assistance.

(b) The service elements and areas listed below shall be provided within each special care unit:

- (1) A nurses' station located to permit direct visual observation of each patient served;
- (2) Hand washing facilities convenient to nurses' station;
- (3) Designated charting space in addition to monitoring service space;
- (4) A staff toilet room containing a water closet and a lavatory;
- (5) Facilities for the safekeeping of coats and personal effects of staff;
- (6) A clean workroom or a system for storage and distribution of clean supplies. The clean area shall contain a work counter, hand washing facilities and storage facilities;
- (7) A soiled workroom, or a soiled holding room as part of a system for the collection and disposal of soiled materials. The soiled workroom shall contain a clinical sink or other flushing device, a sink equipped for hand washing, and a work counter. A soiled holding room shall be similar to the soiled workroom except that the clinical sink and work counter may be omitted;
- (8) A drug distribution station that meets the current minimum requirements of governing state and federal agencies including lavatory;
- (9) A clean linen storage closet or alcove. This may be a designated area within the clean workroom. If a closed cart system is used, storage may be in a controlled alcove clear of corridor width;
- (10) A nourishment area with a sink, equipment for serving nourishment between meals, a refrigerator, and storage facilities. New or replacement ice dispensing equipment for patient service shall be of a self-dispensing type that will not require use of utensils;
- (11) Storage area for emergency and other rolling equipment outside of corridor width;
- (12) Secure facilities for storage of patients' personal effects;
- (13) Bedpan washing devices; and
- (14) A separate waiting room with seating accommodations for visitors, a toilet room, and a public telephone. The



waiting room may serve more than one special care unit.

*Statutory Authority G.S. 131E-79.*

## **.6203 NEONATAL LEVEL I NURSERY UNIT**

(a) Neonatal infant units shall be on the same floor as post-partum nursing units. No nursery shall open directly into another nursery. Each nursery shall contain the following:

- (1) Lavatory located within 10 feet travel distance of each bassinet;
- (2) Emergency calling system;
- (3) Glazed observation windows for viewing infants from public areas; and
- (4) Charting facilities.

(b) A full term nursery shall contain not more than 24 bassinets. The minimum floor area per bassinet shall be 30 square feet clear and there shall be 3 feet clear in all directions around each bassinet.

(c) Each nursery shall be served by a connecting workroom. It shall contain gowning facilities at the entrance for staff and housekeeping personnel, lavatory, and storage area. One workroom may serve more than one nursery.

(d) Space for examination and treatment shall contain a counter, storage, and a lavatory. It may serve more than one nursery room and may be located in a workroom.

(e) If commercially-prepared formula is not used, space and equipment to accommodate the handling, storage, and preparation of formula shall be provided.

(f) A janitor's closet for the exclusive use of the housekeeping staff in maintaining the nursery suite shall be provided. It shall contain a floor receptor or service sink and storage space for housekeeping equipment and supplies.

(g) Doors to nurseries shall be no less than three feet wide. If doors are provided directly from nurseries to public corridors or public spaces, they shall be equipped with "one-way" hardware for exit only to prevent unauthorized entry.

(h) Smoke detection shall be provided in each nursery bed space.

*Statutory Authority G.S. 131E-79.*

## **.6204 NEONATAL LEVEL II AND III NURSERY**

(a) Units shall be accessible to post-partum nursing and delivery units.

(b) The nursery shall be located and arranged to

preclude unrelated traffic through the nursery.

(c) Each nursery shall contain the following:

- (1) Lavatory located within ten feet travel distance of each bassinet;
- (2) Emergency calling system; and
- (3) Charting facilities.

(d) There shall be six feet between bassinets for neonatal care units and five feet between bassinets for intermediate care units. Neonatal care nurseries shall have 80 square feet per bassinet not including corridors and cabinets. Intermediate care nurseries shall have 50 square feet per bassinet not including cabinets and corridors. Corridors or aisles shall have at least eight feet of clear width for access to bassinets.

(e) Each nursery shall be served by a connecting workroom. It shall contain gowning facilities at the entrance for staff and housekeeping personnel, lavatory, and storage. One workroom may serve more than one nursery. The workroom may be omitted if equivalent work area and facilities are provided within the nursery. Gowning and hand washing facilities shall be provided at the entrance to each nursery.

(f) Space for examination and treatment shall be provided and shall contain a counter, storage, and lavatory. It may serve more than one nursery room and may be located in a workroom.

(g) If commercially prepared formula is not used, space and equipment to accommodate the handling, storage, and preparation of formula shall be provided.

(h) A janitor's closet for the exclusive use of the housekeeping staff in maintaining the nursery suite shall be provided. It shall contain a floor receptor or service sink and storage space for housekeeping equipment and supplies.

(i) Doors to nurseries shall be no less than three feet wide. If doors are provided directly from nurseries to public corridors or public spaces, they shall be equipped with "one-way" hardware for exit only to prevent unauthorized entry.

(j) Smoke detection shall be provided in each nursery bed space.

*Statutory Authority G.S. 131E-79.*

## **.6205 PSYCHIATRIC UNIT**

When a facility elects to establish an identifiable psychiatric unit, the following requirements shall be met:

(1) Patient rooms shall meet the requirements of Rule .6201 of this Section with the following exceptions:

(a) Patient room doors shall be designed

with hardware that will permit the doors to swing into the corridors by the use of a special tool for emergency purposes;

- (b) Patient room doors shall be lockable from the corridor side only;
- (c) Outside wall corners shall be omitted where possible;
- (d) The ceiling shall be of monolithic construction and the air distribution devices, lighting fixtures, sprinkler heads, and other appurtenances shall be of the security type;
- (e) Oxygen and suction outlets are not required;
- (f) All windows shall have security screens or be designed to prevent escape and shall be openable without keys or tools; and
- (g) Each patient room shall be provided with a private toilet that meets the following requirements:
  - (i) The door shall not be lockable;
  - (ii) The door shall be capable of swinging outward;
  - (iii) Where provided, electrical outlets shall be protected by ground fault interrupting devices; and
  - (iv) A nurse call system is not required where the documented programmatic demands of the facility prohibit its use.
- (2) The service areas noted in Rule .6201 of this Section and the following shall be provided:
  - (a) Consultation room;
  - (b) Examination and treatment room for exclusive use of the psychiatric unit located within the unit;
  - (c) A conference room for exclusive use of the psychiatric unit located within the unit;
  - (d) Space for dining and recreation with a total area of 35 square feet per patient;
  - (e) Storage closets or cabinets for recreational and occupational therapy equipment; and
  - (f) Storage facilities for patients' personal effects.

Statutory Authority G.S. 131E-79.

#### **.6206 SURGICAL DEPARTMENT REQUIREMENTS**

- (a) Each operating room shall have an

emergency communication system connected to the operating suite control station.

(b) A separate room for post-anesthesia recovery of surgical patients shall be provided. This space shall be arranged to provide and include direct observation of all patients, medicine dispensing facilities, hand washing facilities, charting facilities, flushing device, and storage space for supplies and equipment. A toilet room for nursing staff with water closet and lavatory shall be provided adjacent to recovery room. Provisions shall also be made for observation and isolation of infectious patients.

(c) Service areas shall be provided in individual rooms when so noted; otherwise, alcoves or other open space which will not interfere with traffic may be used. Services, except for the soiled workroom and the janitor's closet, may be shared with and organized as a part of the obstetrical facilities. The following service areas shall be provided:

- (1) An operating suite control station. The station shall be located to permit visual surveillance of all traffic which enters the operating suite or provisions shall be made to prevent unauthorized entry into the suite;
- (2) Supervisor's office or station;
- (3) Sterilizing facilities with a high speed autoclave located to serve the operating rooms;
- (4) Medicine dispensing facilities;
- (5) Scrub stations adjacent to each operating room and arranged to minimize any incidental splatter on nearby personnel or supply carts. A minimum of two scrub sinks per operating room shall be provided. Facilities with no more than three operating rooms may reduce the number of scrub sinks to four;
- (6) A soiled workroom containing a flushing device, a work counter, and a sink equipped for hand washing;
- (7) A soiled linen holding room with a sink equipped for hand washing. This service may be combined with soiled workroom and/or trash holding room;
- (8) A trash holding room with a sink equipped for hand washing. This service may be combined with the soiled workroom and/or soiled linen holding room;
- (9) Clean workroom or clean supply room when clean materials require assembly



prior to use and this assembly is performed within the surgical suite. This room shall contain a work counter, a sink equipped for hand washing and space for clean and sterile supplies. A clean supply room shall be provided when the program defines a system for the storage and distribution of clean and sterile supplies which would not require the use of a clean workroom;

- (10) Anesthesia storage. If facility bylaws do not prohibit flammable anesthetics, a separate room shall be provided for storage of flammable gases;
- (11) Anesthesia workroom with a work counter and sink for cleaning, testing, and storage of anesthesia equipment;
- (12) A room for storage of medical gas reserve cylinders;
- (13) Equipment storage room for equipment and supplies used in surgical suite;
- (14) Staff clothing change areas appropriate for male and female personnel working within the surgical suite. These areas shall contain lockers, showers, toilets, lavatories, and space for donning scrub suits and boots. These areas shall be arranged to provide a one-way traffic pattern so that personnel entering from outside the surgical suite can change, shower, gown and move directly into the surgical suite;
- (15) Patients' holding area to accommodate stretcher patients waiting for surgery. This waiting area shall be under the visual control of operating room staff and shall be in a room or in an alcove out of the direct line of normal traffic;
- (16) Storage area for stretchers out of the corridor width;
- (17) Staff lounges and toilet facilities for staff located to facilitate use without leaving the surgical suite; and
- (18) Janitors' closet containing a floor receptor or service sink and storage space for housekeeping supplies and equipment for the exclusive use of the surgical suite.

*Statutory Authority G.S. 131E-79.*

#### **.6207 OUTPATIENT SURGICAL FACILITIES**

(a) When a facility elects to share outpatient surgical facilities with inpatient surgical facilities,

the outpatient operating room and support areas shall meet the same physical plant requirements as inpatient, general operating rooms and support areas.

(b) When a facility elects to provide separate, non-sharable outpatient surgical facilities, the operating rooms and support areas shall meet the physical plant construction requirements of Outpatient Surgical Licensure requirements of 10 NCAC 3Q .1400.

*Statutory Authority G.S. 131E-79.*

#### **.6208 OBSTETRICAL DEPARTMENT REQUIREMENTS**

(a) The obstetrical unit shall be located so as to prevent unrelated traffic through the unit and to provide for every reasonable protection of mothers from infection and from cross-infection.

(b) The standards of the American College of Obstetricians and Gynecologists as outlined in the most current edition of the "Standards for Obstetric-Gynecologic Services" shall be used as a guide.

(c) An emergency communication system connected to the operations and control station shall be provided by the facility.

(d) Resuscitation facilities for neonates shall be provided within the obstetrical unit and convenient to the delivery room.

(e) A labor room shall be provided and shall meet the following requirements:

- (1) A minimum of 80 sq. ft. of area shall be provided per labor bed;
  - (2) The labor rooms shall be located so as to permit visual observation of each room from the nurses' work station;
  - (3) Labor rooms shall afford privacy, and shall be conveniently located with reference to the delivery room;
  - (4) If labor rooms also serve as birthing rooms, they shall be equipped to handle obstetric and neonatal emergencies;
  - (5) A labor room shall contain facilities for medication, hand washing, charting, and storage for supplies and equipment;
  - (6) At least one shower with direct access from within the delivery unit shall be provided;
  - (7) At least two labor beds with adjacent toilet shall be provided for each delivery room; and
  - (8) No more than two labor beds may be located in one labor room.
- (f) A toilet with hand-washing facilities shall be

provided for the staff.

(g) A separate recovery room may be omitted in facilities with less than 1500 births per year. When provided, the recovery room shall meet the following requirements:

- (1) A recovery room shall contain not less than two beds and shall have charting facilities located so as to permit visual observation of all beds;
- (2) Provisions for medicine dispensing, hand washing, clinical sink with bedpan washer, and storage for supplies and equipment shall be provided; and
- (3) A toilet with hand washing facilities shall be provided for staff.

(h) When a facility elects to provide labor, delivery and recovery room (LDR) service as a part of its total services, the following requirements shall be met:

- (1) Each labor, delivery and recovery room shall have a minimum of 250 square feet of floor space exclusive of toilet room, closet, or vestibule;
- (2) A toilet directly accessible from each labor, delivery and recovery room shall be provided for use by that room only and equipped with a clinical sink or other suitable flushing device for emptying bed pans;
- (3) Each labor, delivery and recovery room shall be provided with directly accessible shower for use by that room only;
- (4) Each labor, delivery and recovery room shall be equipped with oxygen, suction, medical air, and electrical outlets; and
- (5) Each labor, delivery and recovery room shall contain facilities for medication, hand washing, charting, and storage for supplies and equipment.

(i) When a facility elects to provide labor, delivery, recovery and postpartum (LDRP) service as a part of its total services the following requirements shall be met:

- (1) Each labor, delivery, recovery and postpartum room shall meet the requirements listed in Rule .6208 (h) of this Section; and
- (2) Each labor, delivery, recovery and postpartum room shall be counted as a single patient room for purposes of determining the facility's bed capacity.

(j) The following shall be provided:

- (1) If analgesia is used, beds shall be equipped with side rails; and

- (2) There shall be facilities for examination and preparation of patients as required by the attending physician.

(k) The obstetrical (OB) unit shall be provided with the following services either in individual rooms, alcoves, or other open spaces not subject to traffic:

- (1) Scrub facilities with stations located adjacent to each pair of delivery rooms and arranged to minimize incidental splatter on nearby personnel or supply carts;
- (2) A storage room for equipment and supplies;
- (3) One delivery room with support services meeting the requirements of a surgical operating room and support services referenced in Rule .6206 of this Section if caesarean sections are to be performed in the obstetrical delivery unit; and
- (4) One janitor's closet exclusively for use by the obstetrics unit.

(l) The obstetrical unit shall be provided with the following services either in individual rooms, alcoves, or other open spaces not subject to traffic, however, they may be located either in the obstetrics unit or may be shared with the surgical unit if arranged so as to avoid cross traffic between the surgical and obstetrics units:

- (1) Delivery unit control station located so as to permit visual surveillance of all traffic which enters the obstetrical unit;
- (2) Supervisor's office or station;
- (3) Medicine dispensing facilities;
- (4) Scrub facilities with stations located adjacent to each pair of delivery rooms and arranged so as to minimize incidental splatter on nearby personnel or supply carts;
- (5) Soiled workroom or a soiled holding room as a part of a system for the collection and disposal of soiled materials:
  - (A) A soiled workroom may not be shared with the surgical unit and shall contain a flushing device, a work counter and sink equipped for hand washing, a waste receptacle, and a linen receptacle; and
  - (B) A soiled holding room may be shared with the surgical unit and shall be similar to the soiled workroom except that the flushing device and work counter may be omitted.



Fluid waste disposal facilities convenient to the delivery rooms; the flushing device in a soiled workroom meets this requirement;

- (6) Staff clothing change areas appropriate for male and female personnel working within the obstetrics unit including lockers, shower, toilet, and lavatory, and space for donning scrub suit and boots;
- (7) Lounge and toilet facilities for obstetrical staff;
- (8) Stretcher storage provisions out of direct line of traffic;
- (9) Clean workroom, or clean supply room:
  - (A) A clean workroom or supply room is required when clean materials require assembly prior to use and this assembly is performed within the obstetrics unit; and
  - (B) Clean workroom shall contain a work counter, a sink equipped for hand washing, and space for clean and sterile supplies;
- (10) Anesthesia workroom for the cleaning, testing, and storage of anesthesia equipment with a work counter and sink;
- (11) Space for storage of nitrous oxide and oxygen cylinders;
- (12) A storage room for equipment and supplies used in a surgical unit;
- (13) Delivery room(s) used for no other purpose than for the completion of labor and delivery and including a minimum clear area of 300 square feet, exclusive of fixed and movable cabinets and shelves. The minimum room dimension shall be 16 feet; and
- (14) One delivery room meeting the following requirements if caesarean sections are to be performed in the obstetrics unit:
  - (A) The delivery room shall meet the requirements for surgical operating rooms; and
  - (B) Support services required for surgical operating rooms shall be provided.

Subchapter shall determine the type facilities to be provided.

(b) When a facility provides emergency services under one of the classifications listed in Section .4100 of this Subchapter, the following shall be provided:

(1) Level I, II, III:

- (A) a drive at grade level with provision for ambulance and pedestrian service and a well marked covered entrance with a minimum clear passage height of 12 feet 8 inches and a clear width of 16 feet;
- (B) public waiting space with toilet facilities, telephone, drinking fountain, stretcher, and wheelchair storage;
- (C) nurses' work and charting space shall be provided. This may be combined with reception and control area for Level III;
- (D) storage for clean supplies and equipment. Facilities shall be available for the administration of blood, blood plasma, and intravenous medication as well as for the control of bleeding, emergency splinting of fractures, and the administration of oxygen, anesthesia, and suction;
- (E) soiled holding area with flushing device;
- (F) janitor's closet with service sink;
- (G) patient toilets; and
- (H) staff toilets.

(2) Level I, II:

- (A) a reception and control area that is staffed around the clock;
- (B) visual control of the entrance, waiting room, and treatment area shall be maintained;
- (C) communication with other facility departments;
- (D) at least one treatment room shall be available around the clock for the examination and initial treatment of emergency patients. This room shall be independent of the operating room;
- (E) treatment rooms or areas shall contain cabinets, medication storage, work counters, X-ray film illuminators, and space for storage of emergency equipment;
- (F) the size of the rooms or areas shall allow for a minimum of 3 feet clear on three sides of each stretcher; and

*Statutory Authority G.S. 131E-79.*

## **.6209 EMERGENCY SERVICES**

(a) The minimum requirements for emergency care required under Section .4100 of this

- (G) hand washing facilities shall be provided.

Statutory Authority G.S. 131E-79.

#### .6210 IMAGING SERVICES

Imaging services include fluoroscopy, radiography, mammography, computerized tomography scanning, ultrasound, magnetic resonance, angiography and other similar techniques.

- (1) Radiology services are required for all facilities and shall contain the following:
  - (a) Radiographic and fluoroscopic rooms;
  - (b) Film processing equipment;
  - (c) Administration and viewing areas;
  - (d) Provisions for film storage;
  - (e) Toilet room with hand washing facilities immediately accessible to each fluoroscopy and radiography room;
  - (f) Dressing area with immediate access to toilets;
  - (g) Waiting room or alcove for patients;
  - (h) Holding area for stretcher patients out of corridor width; and
  - (i) A shielded control alcove with a view window for full view of patient.
- (2) Angiography services are not required for licensure; however, when this service is provided it shall have the following:
  - (a) Procedure room sized to accommodate and service the equipment purchased but having a minimum area of 400 square feet;
  - (b) A control room with a view window that permits a full view of the patient;
  - (c) A designated radiographic view area having a minimum length of 10 feet (3.05 meters);
  - (d) Scrub sink outside staff entrance to the procedure room;
  - (e) Patient holding area large enough to accommodate two stretchers out of the corridor width;
  - (f) Storage area for portable equipment and supplies out of the corridor width; and
  - (g) Post procedure observation area for patients.
- (3) Computerized Tomography (CT) Scanning service is not required for licensure; however, when this service is provided, the following shall be provided:
  - (a) Procedure room sized to accommodate and service the equipment purchased;

- (b) Control room with a view window to permit full view of the patient;
  - (c) Film processing area adjacent to the control room;
  - (d) Patient toilet accessible to the procedure room located to permit the patient to exit the toilet without reentering the procedure room; and
  - (e) At least one emergency light located in the procedure room.
- (4) Magnetic Resonance Imaging (MRI) service is not required for licensure; however, when this service is provided the following shall be provided:
- (a) Procedure and support rooms sized to accommodate and service the equipment purchased;
  - (b) A control room with full view of the patient and MRI unit and having a minimum area of 100 square feet;
  - (c) A patient holding area located near the MRI unit and large enough to accommodate stretchers out of the corridor width;
  - (d) Patient toilet accessible to the procedure room and located to permit the patient to exit the toilet without reentering the procedure room; and
  - (e) At least one emergency light located in the procedure room.
- (5) Design and performance specifications related to the radiation shielding of imaging rooms shall be furnished by a qualified physicist approved by the Radiation Protection Division of the N.C. Department of Environment Health and Natural Resources.

Statutory Authority G.S. 131E-79.

#### .6211 LABORATORY SERVICES

Laboratory services may be provided within the facility or through contract with a laboratory service. If laboratory services are offered within the facility, then the following shall be provided:

- (1) Laboratory work counter with sink, vacuum, gas and electrical outlets;
- (2) Lavatory or counter sinks equipped for hand washing;
- (3) Blood storage equipment with temperature monitoring and alarm signals; and
- (4) Specimen collection:
  - (a) Urine collection rooms shall be equipped with a water closet and



- (b) lavatory; and  
Blood collection area shall have space for a chair, work counter, and hand washing sink.

*Statutory Authority G.S. 131E-79.*

## .6212 MORGUE

(a) Where facilities have an agreement to transfer bodies within six hours of death, a single room large enough to contain a stretcher is acceptable.

(b) When autopsies are conducted at the facility, the morgue shall be directly accessible to the service entrance or an outside entrance, and shall be located to avoid movement of bodies through lobbies and other public areas. The following elements shall be provided:

- (1) Refrigeration equipment for body-holding; and
- (2) Autopsy room containing:
  - (A) Work counter with sink equipped for hand washing;
  - (B) Storage space for supplies, equipment, and specimens;
  - (C) Autopsy table;
  - (D) A deep sink for washing of specimens;
  - (E) Clothing change area with shower, toilet, and lockers; and
  - (F) Janitor's closet with service sink or receptor.

(c) Where no transfer agreement exists with another facility, or bodies cannot be transferred within six hours or autopsies are not conducted at the facility, a well ventilated, temperature controlled body-holding room shall be provided.

*Statutory Authority G.S. 131E-79.*

## .6213 PHARMACY SERVICES

The size of the pharmacy and the type of services to be provided in the pharmacy will depend upon the facility mission statement, the type of drug distribution system to be used in the facility, and the extent of shared or purchased services. When pharmacy services are planned, provisions shall be made for the following:

- (1) Administrative functions including pick-up and receiving, requisition processing, drug information and storage for general supplies, volatile fluids and alcohol;
- (2) Quality control area with sufficient counter space when bulk compounding and packaging functions are performed;

- (3) Secure storage for controlled substances;
- (4) An area for temporary storage, exchange and restocking of carts; and
- (5) Hand washing facilities within each separate room where open medication is handled.

*Statutory Authority G.S. 131E-79.*

## .6214 DIETARY SERVICES

(a) Construction, equipment, and installation shall comply with the standards of the N.C. Department of Environment, Health and Natural Resources.

(b) The following shall be provided to implement the type of food service system outlined in the hospital's mission statement:

- (1) Control station for receiving food supplies;
- (2) Space for four days' food supply including refrigeration space is required for a conventional food preparation system;
- (3) Food preparation space for conventional food preparation equipment needed in preparing, cooking, and baking foods; convenience food service systems (frozen prepared meals, bulk packaged entrees, individual packaged portions, etc.) or systems utilizing contractual commissary services require space and equipment for thawing, portioning, cooking and baking. In addition, a lavatory shall be provided in the food preparation area;
- (4) Tray assembly and distribution space;
- (5) Dining space for ambulatory patients, staff, and visitors;
- (6) Dietary office;
- (7) Locker room and toilet facilities for dietary staff;
- (8) Storage space for housekeeping equipment and supplies located within the dietary department, including a floor receptor or service sink; and
- (9) Ice making equipment convenient to salad preparation area and cafeteria.

*Statutory Authority G.S. 131E-79.*

## .6215 ADMINISTRATION

(a) The facility entrance shall be at grade level, sheltered from the effects of inclement weather, and able to accommodate wheelchairs and stretchers.

(b) The entrance lobby shall contain:

- (1) Reception and information counter or desk;
- (2) Waiting space;
- (3) Storage area(s) for wheelchairs and stretchers;
- (4) Public toilets;
- (5) Public telephone; and
- (6) Drinking fountain.

(c) Private interview space shall be provided.

(d) Office spaces for administrative staff shall be provided.

(e) Medical library shall be provided.

(f) Staff toilets shall be provided.

(g) Storage for office equipment and supplies shall be provided.

(h) A janitor's closet containing a floor receptor or service sink and storage space for housekeeping equipment and supplies shall be provided.

*Statutory Authority G.S. 131E-79.*

#### **.6216 MEDICAL RECORDS SERVICES**

Medical records services shall include the following:

- (1) Medical record director's office or space;
- (2) A separate review and dictating room;
- (3) Work area for sorting, recording, or microfilming records;
- (4) Storage area for records; and
- (5) An approved smoke detection system, interconnected with the facility fire alarm system if medical records are stored in a separate building.

*Statutory Authority G.S. 131E-79.*

#### **.6217 CENTRAL MEDICAL AND SURGICAL SUPPLY SERVICES**

(a) A separate receiving room shall be provided and shall contain work space and equipment for initial sterilization and disinfection of medical and surgical equipment and for disposal or processing of unclean articles. Hand washing facilities shall be provided.

(b) A separate clean workroom shall be provided and shall contain work space and equipment for sterilizing medical and surgical equipment and supplies. Storage areas for clean supplies and for sterile supplies shall be included in this room.

(c) A separate storage room for assembly, final packaging, and storage of sterile supplies and equipment shall be provided.

(d) A storage room for unsterile supplies and

equipment shall be provided but may be located in another area of the facility.

(e) Provisions shall be made for cleaning and sanitizing carts serving the central supply services, dietary services, and linen services departments and may be centralized or departmentalized.

*Statutory Authority G.S. 131E-79.*

#### **.6218 GENERAL STORAGE**

General storage room(s) shall have a total area of not less than 20 square feet (1.86 square meters) per inpatient bed and shall be concentrated in one area but may be divided in a multiple building complex and shall include:

- (1) Receiving area; and
- (2) Off street loading area.

*Statutory Authority G.S. 131E-79.*

#### **.6219 LAUNDRY SERVICES**

(a) When the facility elects to provide its own laundry, the laundry shall contain the following:

- (1) A soiled linen holding room;
- (2) A designated clean linen storage area unless a closed linen cart system is utilized;
- (3) A linen cart cleanup and storage area;
- (4) Toilet facilities accessible to employees from soiled linen, clean linen, and laundry processing;
- (5) Laundry processing area with hand washing facilities and commercial type equipment which can process seven days' needs within a scheduled work week;
- (6) A janitor's closet containing a floor receptor or service sink and storage space for housekeeping equipment and supplies; and
- (7) Supply storage.

(b) When the facility elects to contract for laundry service off premises it shall provide the following:

- (1) Soiled linen holding room;
- (2) Clean linen holding room;
- (3) Linen cart cleanup and storage room; and
- (4) Hand washing facilities.

*Statutory Authority G.S. 131E-79.*

#### **.6220 PHYSICAL REHABILITATION SERVICES**

When physical rehabilitation services are offered



in the facility, the following shall be provided:

- (1) Patient waiting space, with provisions for wheelchair patients and stretcher patients;
- (2) Office space;
- (3) Patients' toilet;
- (4) Hand washing facilities;
- (5) Treatment areas or room that provides visual privacy (visual privacy not required for Occupational Therapy and Speech Therapy);
- (6) Soiled linen storage (not required for Occupational Therapy and Speech Therapy);
- (7) Clean linen storage (not required for Occupational Therapy and Speech Therapy);
- (8) Equipment storage; and
- (9) Wheelchair and stretcher storage.

Statutory Authority G.S. 131E-79.

#### .6221 ENGINEERING SERVICES

The following provisions for engineering services shall be included:

- (1) A room or separate building for boilers, mechanical equipment, and electrical equipment;
- (2) Office;
- (3) Maintenance shop;
- (4) Maintenance supplies storage room; and
- (5) Locker and toilet rooms for engineering service employees.

Statutory Authority G.S. 131E-79.

#### .6222 WASTE PROCESSING

Each facility shall provide for the processing and disposing of all waste products in accordance with local city and county requirements and the requirements of the N.C. Department of Environment Health and Natural Resources and shall produce evidence of approval from each authority having jurisdiction prior to the start of facility operation.

Statutory Authority G.S. 131E-79.

#### .6223 DETAILS AND FINISHES

(a) All details and finishes for modernization projects as well as for new construction shall meet the following requirements:

- (1) All rooms containing baths, showers, and toilets, subject to patient occupancy, shall be equipped to open from the outside without the use of a

key in any emergency;

- (2) Doors in all openings between corridors and rooms or spaces subject to occupancy shall be of the side hinged type or an approved sliding type door;
  - (3) No doors shall swing into corridors in a manner that might obstruct traffic flow or reduce the required corridor width except for doors to spaces such as closets less than 25 square feet in floor area, which are not subject to occupancy;
  - (4) Grab bars shall be provided at all patient toilets, showers, and tubs. Grab bars shall have not less than 2-1/2 inch clearance to the wall or support and shall be capable of supporting not less than a 250 pound concentrated load;
  - (5) Single use soap dispensers, towel dispensers or air driers shall be provided at all hand washing fixtures except scrub sinks;
  - (6) All rooms shall have not less than 8 foot high ceilings except that ceilings of corridors, storage rooms, toilet rooms, and other minor rooms shall be no less than 7 feet 6 inches high. Suspended tracks, rails, pipes, etc., located in the path of normal traffic, shall be no less than 7 feet 6 inches above the floor;
  - (7) Rooms containing equipment shall be insulated and/or ventilated to prevent any patient use floor surface above from exceeding a temperature 10 degrees F. above the ambient room temperature; and
  - (8) Approved fire extinguishers shall be provided throughout the building to comply with National Fire Protection Association Standard 10.
- (b) Finishes shall meet the following requirements:
- (1) Floors in areas used for food preparation or food assembly shall be water, oil and slip resistant. Joints in tile and similar material in such areas shall be resistant to food acids. In all areas subject to frequent wet cleaning, floors shall not be physically affected by germicidal and cleaning solutions. Floors that are subject to traffic while wet, as in kitchens, showers, and bath areas and similar work areas, shall have a non-slip surface;
  - (2) Floors and wall bases in operating and

- delivery rooms shall be joint free. Wall bases shall be tightly sealed within the wall and constructed without voids that can harbor vermin;
- (3) Floors and wall bases in kitchens, soiled workrooms, and other areas subject to frequent wet cleaning, shall be made integral with the floor, tightly sealed to the wall, and constructed without voids that can harbor vermin;
  - (4) Walls shall be washable. In the immediate area of plumbing fixtures, the finish shall be smooth, moisture resistant, and easily cleanable;
  - (5) Floor and wall penetrations and joints of structural elements shall be tightly sealed to minimize entry of rodents and insects;
  - (6) Ceilings throughout shall be easily cleanable. Those in operating and delivery rooms, nurseries, and other sensitive areas shall be readily washable and without crevices that can retain dirt particles. These sensitive areas along with the dietary and food preparation areas shall have a finished ceiling covering all overhead ductwork, etc. Finished ceilings may be omitted in mechanical and equipment spaces, shops, general storage areas, and similar spaces except where required for fire rating;
  - (7) In psychiatric patient rooms, toilets, and seclusion rooms, the ceiling shall be of monolithic construction. Air distribution devices, lighting fixtures, sprinkler heads, and other appurtenances shall be of the security type. All windows shall have security screens or be designed to prevent escape and shall be openable without keys or tools;
  - (8) Rooms used for protective isolation shall not have carpet. Ceilings shall be of monolithic construction; and
  - (9) Rooms where impact noises are generated shall not be located directly over or under patient bed areas, and delivery or operating suites unless special provisions are made to minimize noise.

Statutory Authority G.S. 131E-79.

## .6224 ELEVATOR REQUIREMENTS

Elevators shall meet the following:

- (1) Facilities with patient areas located on

other than the grade-level entrance floor shall have at least one hospital-type elevator;

- (2) In the absence of an engineered traffic study, the following guidelines for number of elevators shall apply:
  - (a) At least one hospital-type elevator shall be installed when 60 patient beds or less are located on any floor other than the main entrance floor;
  - (b) At least two hospital-type elevators shall be installed when 61 to 200 patient beds are located on floors other than the main entrance floor, or where inpatient services are located on a floor other than those containing patient beds. Elevator service may be reduced for those floors providing only partial inpatient services;
  - (c) At least three hospital-type elevators shall be installed where 201 to 350 patient beds are located on floors other than the main entrance floor, or where inpatient services are located on a floor other than those containing patient beds. Elevator service may be reduced for those floors providing only partial inpatient services; and
  - (d) For facilities with more than 350 beds the number of elevators shall be determined from an engineering study of the facility plan and the expected vertical transportation requirements.
- (3) Hospital-type elevator cars shall have inside dimensions that will accommodate a patient's bed with attendants. Cars shall be at least five feet (1.52 meters) wide by seven feet six inches (2.29 meters) deep. Car doors shall have a clear opening of not less than four feet (1.22 meters) wide and seven feet (2.13 meters) high; and
- (4) Elevators, except freight elevators, shall be equipped with a two-way service switch for staff use for bypassing all landing button calls and traveling directly to any floor.

Statutory Authority G.S. 131E-79.



**.6225 MECHANICAL REQUIREMENTS**

(a) Prior to occupancy of the facility, the facility shall obtain documentation verifying that all mechanical systems have been tested, balanced, and operated to demonstrate that the installation and performance of these systems conform to the approved design. Test results shall be maintained in the facility maintenance files.

(b) Upon completion of equipment installation, the facility shall acquire and maintain a complete set of manufacturers' operating, maintenance, and preventive maintenance instructions, parts lists, and procurement information including equipment numbers and descriptions.

(c) Operating staff shall be provided with instructions for properly operating systems and equipment.

(d) The facility structure, component parts, and building systems shall be kept in good repair and maintained with consideration for the safety and comfort of patients, staff and visitors.

(e) There shall be a definite assignment of maintenance functions to qualified personnel under supervision.

(f) General design requirements shall meet the following:

(1) Heating plants shall be adequate to maintain a cold weather temperature of 70 degrees F. (21.1 degrees C.) in all rooms used by patients;

(2) Boilers shall have capacity to supply all the heating functions of the facility. The number and arrangement of boilers shall accommodate the facility's needs despite the breakdown or routine maintenance of any one boiler;

(3) Insulating materials shall be provided within the facility to conserve energy, protect personnel, prevent vapor condensation, and reduce unnecessary noise and vibration;

(4) Facility design considerations shall include recognized energy saving measures. When using variable air volume systems within the facility special care shall be taken to assure that minimum ventilation rates and pressure relationships between various departments are maintained;

(5) The general air pressure relationships, ventilation rates, and relative humidity requirements of Table 1 shall be maintained;

**Table 1**  
**Ventilation Requirements for Areas Affecting Patient Care in Hospitals and Skilled Nursing Units and Outpatient Facilities in Hospitals<sup>1</sup>**

<u>Area Designation</u>	<u>Air movement relationship to adjacent area<sup>2</sup></u>	<u>Minimum air changes of outdoor air per hour<sup>3</sup></u>	<u>Minimum total air changes per hour<sup>4</sup></u>	<u>All air exhausted directly to outdoors<sup>5</sup></u>	<u>Recirculated by means of room units<sup>6</sup></u>	<u>Relative humidity (%)<sup>7</sup></u>	<u>Design temperature (° F/° C)<sup>8</sup></u>
<b><u>Surgery and Critical Care</u></b>							
<u>Operating room<sup>9</sup></u>	<u>Out</u>	<u>3</u>	<u>15</u>	<u>=</u>	<u>No</u>	<u>50-60</u>	<u>70-75/21-24</u>
<u>Delivery room<sup>9</sup></u>	<u>Out</u>	<u>4</u>	<u>15</u>	<u>=</u>	<u>No</u>	<u>45-60</u>	<u>70-75/21-24</u>
<u>Recovery room<sup>9</sup></u>	<u>=</u>	<u>2</u>	<u>6</u>	<u>=</u>	<u>No</u>	<u>30-60</u>	<u>70/21</u>
<u>Special care</u>	<u>=</u>	<u>2</u>	<u>6</u>	<u>=</u>	<u>No</u>	<u>30-60</u>	<u>70-75/21-24</u>
<u>Treatment room<sup>10</sup></u>	<u>=</u>	<u>=</u>	<u>6</u>	<u>=</u>	<u>=</u>	<u>=</u>	<u>75/24</u>
<u>Trauma room<sup>10</sup></u>	<u>Out</u>	<u>3</u>	<u>15</u>	<u>=</u>	<u>No</u>	<u>45-60</u>	<u>70-75/21-24</u>
<u>Anesthesia gas storage</u>	<u>=</u>	<u>=</u>	<u>8</u>	<u>Yes</u>	<u>=</u>	<u>=</u>	<u>=</u>
<b><u>NURSING</u></b>							
<u>Patient room</u>	<u>=</u>	<u>1</u>	<u>2</u>	<u>=</u>	<u>=</u>	<u>=</u>	<u>70-75/21-24</u>
<u>Toilet room</u>	<u>In</u>	<u>=</u>	<u>10</u>	<u>Yes</u>	<u>Yes</u>	<u>=</u>	<u>=</u>
<u>Newborn nursery suite</u>	<u>=</u>	<u>2</u>	<u>6</u>	<u>=</u>	<u>No</u>	<u>30-60</u>	<u>75/24</u>
<u>Protective isolation when provided<sup>11</sup></u>	<u>Out</u>	<u>1</u>	<u>6</u>	<u>=</u>	<u>No</u>	<u>=</u>	<u>70-75/21-24</u>
<u>Infectious isolation when provided<sup>12</sup></u>	<u>In</u>	<u>1</u>	<u>6</u>	<u>Yes</u>	<u>No</u>	<u>=</u>	<u>70-75/21-24</u>
<u>Isolation alcove or anteroom<sup>11,12</sup></u>	<u>In/Out</u>	<u>=</u>	<u>10</u>	<u>Yes</u>	<u>No</u>	<u>=</u>	<u>=</u>
<u>Labor/delivery/recovery</u>	<u>=</u>	<u>=</u>	<u>2</u>	<u>=</u>	<u>=</u>	<u>=</u>	<u>70-75/21-24</u>
<u>Labor/delivery/recovery/postpartum</u>	<u>=</u>	<u>=</u>	<u>2</u>	<u>=</u>	<u>=</u>	<u>=</u>	<u>70-75/21-24</u>
<u>Patient corridor</u>	<u>=</u>	<u>=</u>	<u>2</u>	<u>=</u>	<u>=</u>	<u>=</u>	<u>=</u>

# PROPOSED RULES

<b>ANCILLARY</b>															
<b>Radiology<sup>13</sup></b>															
X-ray (surg/critical care)	Out	3	15	=	No	45-60	70-75/21-24								
X-ray (diagnostic & treat.)	=	=	6	=	=	=	75/24								
Darkroom	In	=	10	Yes	No	=	=								
<b>Laboratory</b>															
General <sup>14</sup>	=	=	6	=	=	=	=								
Biochemistry <sup>14</sup>	Out	=	6	=	No	=	=								
Cytology	In	=	6	Yes	No	=	=								
Glass Washing	In	=	10	Yes	=	=	=								
Histology	In	=	6	Yes	No	=	=								
Microbiology <sup>14</sup>	In	=	6	Yes	No	=	=								
Nuclear medicine <sup>13</sup>	In	=	6	Yes	No	=	=								
Pathology	In	=	6	Yes	No	=	=								
Serology	Out	=	6	=	No	=	=								
Sterilizing	In	=	10	Yes	=	=	=								
Autopsy room	In	=	12	Yes	No	=	=								
Non refrigerated body-holding room <sup>15</sup>	In	=	10	Yes	Yes	=	70/21								
Pharmacy	=	=	4	=	=	=	=								
<b>DIAGNOSTIC AND TREATMENT</b>															
Examination Room	=	=	6	=	=	=	75/24								
Medication room	=	=	4	=	=	=	=								
Treatment room	=	=	6	=	=	=	75/24								
Physical therapy and hydrotherapy	In	=	6	=	=	=	75/24								
Soiled workroom or soiled holding	In	=	10	Yes	No	=	=								
Clean workroom or clean holding	=	=	4	=	=	=	=								
<b>STERILIZING AND SUPPLY</b>															
ETO-sterilizer room <sup>14</sup>	In	=	10	Yes	No	=	75/24								
Sterilizer equipment room <sup>14</sup>	In	=	10	Yes	=	=	=								
Central medical and surgical supply	Out	=	6	=	No	=	=								
Soiled or decontamination room	In	=	4	Yes	=	=	=								
Clean workroom and sterile storage	Out	=	6	=	No	(Max) 20	75/24								
<table> <tr> <th>Area Designation</th><th>Air movement relationship to adjacent area<sup>2</sup></th><th>Minimum air changes of outdoor air per hour<sup>3</sup></th><th>Minimum total air changes per hour<sup>4</sup></th><th>All air exhausted directly to outdoors<sup>5</sup></th><th>Recirculated by means of room units<sup>6</sup></th><th>Relative humidity (%)<sup>7</sup></th><th>Design temperature ° F/ ° C<sup>8</sup></th></tr> </table>								Area Designation	Air movement relationship to adjacent area <sup>2</sup>	Minimum air changes of outdoor air per hour <sup>3</sup>	Minimum total air changes per hour <sup>4</sup>	All air exhausted directly to outdoors <sup>5</sup>	Recirculated by means of room units <sup>6</sup>	Relative humidity (%) <sup>7</sup>	Design temperature ° F/ ° C <sup>8</sup>
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<b>SERVICE</b>															
Food preparation center <sup>17</sup>	=	=	10	=	No	=	=								
Warewashing	In	=	10	Yes	No	=	=								
Dietary day storage	In	=	2	=	=	=	=								
Laundry, general	=	=	10	Yes	=	=	=								
Soiled linen (sorting and storage)	In	=	10	Yes	No	=	=								
Clean linen storage	=	=	2	=	=	=	=								
Soiled linen and trash chute room	In	=	10	Yes	No	=	=								
Bedpan room	In	=	10	Yes	Yes	=	=								
Bathroom	=	=	10	=	=	=	75/24								
Janitor's closet	In	=	10	Yes	No	=	=								

## Table Notes:

- The ventilation rates in this table cover ventilation for comfort, as well as for asepsis and odor control in areas of acute care hospitals that directly affect patient care and are determined based on health care facilities being predominantly "No Smoking" facilities. Where smoking may be allowed, ventilation rates will need adjustments. Specialized patient care areas, including organ transplant units, burn units, specialty procedure rooms, etc., shall have additional ventilation provisions for air quality control as may be appropriate.
- Design of the ventilation system shall provide that air movement is from "clean to less clean" areas. However, continuous compliance may be impractical with full utilization of some forms of variable air volume and load shedding systems that may be used for energy conservation. Areas that do require positive and continuous control are noted with "Out" or "In" to indicate the required direction of air movement in relation to the space named. Rate of air movement may, of course, be varied as needed within the limits required for positive control. Where indication of air movement direction is enclosed in parentheses, continuous directional control is required only when the specialized equipment or device is in use or where room use may otherwise compromise the intent of movement from clean to less clean. Air movement for rooms with dashes and non-patient areas may vary as necessary to satisfy the requirements of those spaces. Additional adjustments may be needed when space is unused or unoccupied and air systems are de-energized or reduced.
- To satisfy exhaust needs, replacement air from outside is necessary. Table 1 does not attempt to describe specific amounts of outside air to be supplied to individual spaces except for certain areas such as those listed. Distribution of the outside air, added to the system to balance required exhaust, shall be as required by good engineering practice.
- Number of air changes may be reduced when the room is unoccupied if provisions are made to ensure that the number of air changes indicated is reestablished any time the space is being utilized. Adjustments shall include provisions so that the direction of air movement shall remain the same when the number of air changes is reduced. Areas not indicated as having continuous directional control may have ventilation systems shut down when space is unoccupied and ventilation is not otherwise needed.
- Air from areas with contamination and/or odor problems shall be exhausted to the outside and not recirculated to other areas. Note that individual



# PROPOSED RULES

circumstances may require special consideration for air exhaust to outside, e.g., in intensive care unit in which patients with pulmonary infection are treated, and rooms for burn patients.

6 Because of cleaning difficulty and potential for buildup of contamination, recirculating room units shall not be used in areas marked "No." Isolation and intensive care unit rooms may be ventilated by reheat induction units in which only the primary air supplied from a central system passes through the reheat unit. Gravity-type heating or cooling units such as radiators or convectors shall not be used in operating rooms and other special care areas.

7 The ranges listed are minimum and maximum limits where control is specifically needed.

8 Dual temperature indications (such as 70-75/21-24) are for an upper and lower variable range at which the room temperature shall be controlled. A single figure indicates a heating or cooling capacity of at least the indicated temperature. This is usually applicable when patients may be undressed and require a warmer environment. Nothing in these rules shall be construed as precluding the use of temperatures lower than those noted when the patients' comfort and medical conditions make lower temperatures desirable. Unoccupied areas such as storage rooms shall have temperatures appropriate for the function intended.

9 For Information Only - National Institute of Occupational Safety and Health (NIOSH) Criteria Documents regarding Occupational Exposure to Waste Anesthetic Gases and Vapors, and Control of Occupational Exposure to Nitrous Oxide indicate a need for both local exhaust (scavenging) systems and general ventilation of the areas in which the respective gases are utilized.

10 The term trauma room as used here is the operating room space in the emergency department or other trauma reception area that is used for emergency surgery. The first aid room and/or "emergency room" used for initial treatment of accident victims may be ventilated as noted for the "treatment room."

11 The protective isolation rooms described in these rules are those that might be utilized for patients with a high susceptibility to infection from leukemia, burns, bone marrow transplant, or acquired immunodeficiency syndrome and that require special consideration for which air movement relationship to adjacent areas would be positive rather than negative. For protective isolation the patient room shall be positive to both anteroom and toilet. Anteroom shall be neutral to corridor. Where requirements for both infectious and protective isolation are reflected in the anticipated patient load, ventilation shall be modified as necessary. Variable supply air and exhaust systems that allow maximum isolation room space flexibility with reversible air movement direction would be acceptable only if appropriate adjustments can be ensured for different types of isolation occupancies. Control of the adjustments shall be under the supervision of the medical staff.

12 The infectious isolation rooms described in these rules are those that might be utilized in the average community hospital. The assumption is made that most isolation procedures will be for infectious patients and that the room is suitable for normal private patient use when not needed for isolation. This compromise obviously does not provide for ideal isolation. The design shall consider types and numbers of patients who might need this separation within the facility. Isolation room shall be negative to anteroom and positive to toilet. Anteroom shall be neutral to corridor.

13 Large hospitals may have separate departments for diagnostic and therapeutic radiology and nuclear medicine. For specific information on radiation precautions and handling of nuclear materials, refer to appropriate sections of requirements developed by the Division of Radiation Protection, NCDEHNR.

14 When required, appropriate hoods and exhaust devices for the removal of noxious gases shall be provided.

15 A non-refrigerated body-holding room would be applicable only for health care facilities in which autopsies are not performed on-site, or the space is used only for holding bodies for short periods prior to transferring.

16 For Information Only - Specific OSHA regulations regarding ethylene oxide (ETO) use have been promulgated. 29CFR Part 1910.1047 includes specific ventilation requirements including local exhaust of the ETO sterilizer area.

17 Food preparation centers shall have an excess air supply for "out" air movements when hoods are not in operation. The number of air changes may be reduced or varied to any extent required for odor control when the space is not in use.

(6) Air duct liners exposed to the air stream shall not be used in ducts serving special care areas or special procedure rooms when such liners are constructed with frangible materials that will enter the air stream;

(7) All central ventilation or air conditioning systems shall be equipped with filters with efficiencies equal to, or greater than, those specified in Table 2. Where two filter beds are required, filter bed No. 1 shall be located upstream of the air conditioning equipment and filter bed No. 2 shall be downstream of any fan or blowers. A manometer shall be installed across each filter bed having a required efficiency of 75 percent or more;

**Table 2**  
**Filter Efficiencies for Central Ventilation and Air Conditioning Systems in General Hospitals**

Area Designation	No. filter beds	Filter bed No. 1	Filter bed No. 2
All areas for inpatient care, treatment, and diagnosis, and those areas providing direct service or clean supplies such as sterile and clean processing, etc.	2	25	90
Protective isolation room when used	2	25	99.7
Laboratories	1	80	=

<u>Administrative, bulk storage, soiled holding areas, food preparation areas, and laundries</u>	<u>1</u>	<u>25</u>	<u>=</u>
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- (8) Any system utilized for occupied areas shall include provisions to avoid air stagnation in interior spaces where comfort demands are met by temperatures of surrounding areas;
- (9) All rooms and areas in the facility used for patient care shall have provisions for year round mechanical ventilation;
- (10) Each patient's room shall have at least one openable window, opening to the outside to permit ventilation; and
- (11) In psychiatric units, all convectors, HVAC enclosures, or air distribution devices that are exposed in the room shall be constructed with rounded corners and shall be fastened with tamper-proof screws.
- (g) Mechanical air intakes shall meet the following:
  - (1) Air intakes shall be located as far as practical but not less than 30 feet (9.14 m.) from exhaust outlets of combustion equipment stacks, ventilation exhaust outlets from the facility or adjoining buildings, medical-surgical vacuum systems or areas that may collect vehicular exhaust or other noxious fumes; and
  - (2) The bottom of the outdoor air intakes shall be at least 6 feet (1.83 m.) above ground level, or if installed above the roof, at least 3 feet (.91 m.) above roof level.
- (h) Mechanical air exhaust/ventilation systems shall meet the following:
  - (1) Fans serving exhaust duct systems shall be located at the discharge end of the duct and shall be readily accessible for servicing; and
  - (2) Exhaust outlets shall be located a minimum of 10 feet (3 m.) above ground and directed away from occupied areas, doors, or openable windows. Prevailing winds, adjacent buildings, and discharge velocities shall be taken into account when designing such outlets.
- (i) Surgery and special care areas shall meet the following:
  - (1) All air shall be supplied at or near the ceiling and removed from at least two remote locations near the floor;
  - (2) Bottom of exhaust or return registers shall be no less than 3 inches (7.62 cm.) above the finished floor level; and
  - (3) Exhaust grilles for anesthesia evacuation and other special applications shall be permitted to be installed in the ceiling.
- (j) Nursery, labor, delivery, recovery, postpartum, and invasive procedure rooms shall meet the following:
  - (1) Air supply shall be at or near the ceiling. Return or exhaust air registers shall be near the floor;
  - (2) Bottom of exhaust or return registers shall be no less than 3 inches (7.62 cm.) above the finished floor level; and
  - (3) Exhaust grilles for anesthesia evacuation and other special applications shall be permitted to be installed in the ceiling.
- (k) Isolation units shall meet the following:
  - (1) Rooms for isolation of patients shall meet the ventilation requirements of Table 1 (See 10 NCAC 03C .6225);
  - (2) A separate anteroom used as an air lock to minimize the potential for airborne particulates from the patients' area reaching adjacent areas shall be provided; and
  - (3) Air supply shall be introduced at or near the ceiling, flowing past the patient, and exhausted or returned at the floor.
- (l) Smoke control/evacuation system(s) shall meet the following:
  - (1) When an engineered smoke control/evacuation system is provided, the system shall incorporate a design of the air duct system(s) and controls to inhibit the migration of smoke from the fire zone to the required means of egress and refuge areas;
  - (2) When an emergency manual control stop switch is provided to shut down supply, return, and exhaust fans, the switch shall be incorporated into the smoke control system in a manner that will not jeopardize the effectiveness or dependability of the smoke control/evacuation system;
  - (3) Static pressure sensors, freeze-stats, or other operating controls shall not jeopardize the



effectiveness of the smoke control system during emergency operation:

- (4) Where smoke dampers are required to be installed as part of a passive smoke control system, smoke dampers shall be installed in ducts that are capable of communicating smoke between floors; and
  - (5) Smoke dampers shall have a maximum air leakage of 10 cubic feet per minute per square foot of damper opening when tested at one inch water gauge of duct pressure. Smoke dampers shall be fail-safe to the emergency position. Dampers shall close upon activation of the fire alarm system unless a part of an engineered smoke control system.
- (m) Laboratories shall meet the following:
- (1) In new construction and renovation work, each hood used to process infectious or radioactive materials shall have a minimum face velocity of 150 feet per minute with static pressure operated dampers and audio-visual alarms to alert staff of ventilation system failure. Each hood shall also have filters with a 99.7 percent efficiency (based on the DOP, dioctyl-phthalate test method) in the exhaust stream, and be designed and equipped to permit the safe removal, disposal, and replacement of contaminated filters; and
  - (2) Each installation shall have an exhaust fan located at the discharge end of the duct system to maintain a negative pressure in the exhaust duct.
- (n) Where ethylene oxide is used, the following requirements shall be met:
- (1) Equipment utilizing ethylene oxide shall be installed in accordance with equipment manufacturer's installation instructions; and
  - (2) An air flow sensing device shall be installed in the exhaust duct. The sensor shall activate a visible and audible signal to alert personnel of ventilation system failure.

*Statutory Authority G.S. 131E-79.*

## **.6226 PLUMBING AND OTHER PIPING SYSTEMS REQUIREMENTS**

(a) A toilet room shall be directly accessible from each patient room and from each central bathing area without going through the general corridor. One toilet room may serve two patient rooms but not more than eight beds. The lavatory may be omitted from the toilet room if one is provided in each patient room.

(b) All plumbing systems shall be installed in such a manner as to completely prevent the possibility of cross connections between safe and unsafe supplies or back siphonage.

(c) The following standards shall apply to plumbing fixtures:

- (1) Lavatories and sinks installed in patient care areas shall have the water spout mounted so that its discharge point is a maximum distance of 5 inches (12.7 cm.) above the rim of the fixture;
- (2) All fixtures used by medical and nursing staff and all lavatories used by patients and food handlers shall be trimmed with valves that can be operated without hands (single-lever devices may be used). Blade handles used for this purpose shall not exceed 4.5 inches (11.4 cm.) in length. Handles on scrub sinks and clinical sinks shall be at least 6 inches (15.2 cm.) long; and
- (3) Showers and tubs shall have non-slip walking surfaces.

(d) The following standards shall apply to potable water supply systems:

- (1) Vacuum breakers shall be installed on hose bibbs and supply nozzles used for connection of hoses or tubing;
- (2) Bedpan-flushing devices shall be provided in each inpatient toilet room; installation is optional in psychiatric and substance-abuse treatment units where patients are ambulatory;
- (3) Potable water storage vessels (hot and cold) not intended for constant use shall not be installed; and
- (4) All piping, except control-line tubing, shall be identified. All valves shall be tagged, and a valve schedule shall be provided to the facility owner for permanent record and reference. Where the functional program includes hemodialysis, continuously circulated filtered cold water shall be provided.

(e) The following standards shall apply to hot water systems:

- (1) The water-heating system shall have sufficient supply capacity at the temperatures and amounts indicated in Table 3. Water temperature is measured at the point of use or inlet to the equipment; and

**Table 3**

Minimum Hot Water Capacity Requirements

	<u>Use</u>		
	<u>Clinical</u>	<u>Dietary</u>	<u>Laundry</u>
<u>Gallons/Hour/Bed</u>	<u>6.5</u>	<u>4</u>	<u>4.5</u>
<u>Liters/Second/Bed</u>	<u>.007</u>	<u>.004</u>	<u>.005</u>
<u>Temperature °F</u>	<u>116</u>	<u>180</u>	<u>180</u>
<u>Temperature °C</u>	<u>46.7</u>	<u>82.2</u>	<u>82.2</u>

- (2) Hot-water distribution systems serving patient care areas shall be under constant recirculation to provide continuous hot water at each hot water outlet. The temperature of hot water for showering and bathing shall be appropriate for comfortable use but shall not exceed 116°F (46.6°C).

(f) The following standards shall apply to drainage systems:

- (1) Drain lines serving some types of automatic blood-cell counters shall be of carefully selected material that will eliminate the potential for undesirable chemical reactions or explosions between sodium azide wastes and copper, lead, brass, and solder;
- (2) Drainage piping shall be installed to avoid installations in the ceiling directly over operating and delivery rooms, nurseries, food preparation centers, food serving facilities, food storage areas, central services, electronic data processing areas, electrical closets, and other sensitive areas. Where overhead drain piping in these areas is unavoidable, special provisions such as auxiliary drain pans shall be installed to protect the space below from leakage;
- (3) Floor drains shall not be installed in operating and delivery rooms, but may be installed in cystoscopic operating rooms;
- (4) Drain systems for autopsy tables shall be designed to avoid splatter or overflow onto floors or back siphonage and for easy cleaning and trap flushing;
- (5) Kitchen grease traps shall be located and arranged to permit easy access without the need to enter food preparation or storage areas; and
- (6) Where plaster traps are used, provisions shall be made for routine access and cleaning.

(g) The performance, maintenance, installation, and testing of medical gas systems, laboratory gas systems, and clinical vacuum systems shall comply with the requirements of the latest edition of National Fire Protection Association Standard 99 and Table 4 for medical gas station outlet requirements. When any piping or supply of medical gases is installed, altered, or augmented, the altered zone shall be tested and certified as required by National Fire Protection Association Standard 99. Testing shall be conducted by the facility and at least one other independent testing organization to ensure that the system is safe for patient use.

**Table 4**

Minimum Medical Gas Station Outlets and Vacuum Station Inlets

<u>Location</u>	<u>Oxygen</u>	<u>Vacuum</u>	<u>Medical Air</u>
<u>Operating Room</u>	<u>2/room</u>	<u>3/room</u>	<u>1/room</u>
<u>Delivery Rooms</u>	<u>2/room</u>	<u>3/room</u>	<u>1/room</u>
<u>Cystoscopy Room</u>	<u>1/room</u>	<u>3/room</u>	<u>-</u>
<u>Special Procedures Room</u>	<u>1/room</u>	<u>3/room</u>	<u>1/room</u>
<u>Other anesthetizing Locations</u>	<u>1/room</u>	<u>3/room</u>	<u>1/room</u>
<u>Recovery Room</u>	<u>1/bed</u>	<u>3/bed</u>	<u>1/bed</u>



<u>Intensive Care Unit</u>	<u>2/bed</u>	<u>3/bed</u>	<u>1/bed</u>
<u>Cardiac Intensive Care Unit</u>	<u>2/bed</u>	<u>2/bed</u>	<u>1/bed</u>
<u>Emergency Room</u>	<u>1/bed</u>	<u>1/bed</u>	<u>1/bed</u>
<u>Trauma Room</u>	<u>2/bed</u>	<u>3/bed</u>	<u>1/bed</u>
<u>Catheterization Lab</u>	<u>1/bed</u>	<u>2/bed</u>	-
<u>Labor Room</u>	<u>1/bed</u>	<u>1/bed</u>	-
<u>Nurseries</u>	<u>1/bassinets</u>	<u>1/bassinets</u>	-
<u>Patient Room</u>	<u>1/bed</u>	<u>1/bed</u>	<u>1/bed</u>
<u>Exam &amp; Treatment Rooms</u>	<u>1/bed</u>	<u>1/bed</u>	-
<u>Anesthesia Workroom</u>	<u>1/room</u>	<u>1/room</u>	<u>1/room</u>
<u>Autopsy Room</u>	-	<u>1/room</u>	-

(h) The line pressure for the medical gases shall be set in the following order:

- (1) Oxygen, highest pressure;
- (2) Medical air, next to lowest pressure; and
- (3) Nitrous oxide, lowest pressure.

*Statutory Authority G.S. 131E-79.*

## **6227 ELECTRICAL REQUIREMENTS**

(a) All material and equipment, including conductors, controls, and signaling devices, shall be installed in compliance with applicable sections of North Carolina State Building Code, Volume VII, Electrical. A written record of performance tests on electrical systems and equipment shall show compliance with applicable codes and standards.

(b) The main switchboard shall be located in an area separate from plumbing and mechanical equipment and shall be accessible to authorized persons only. The main switchboard shall be located in a dry, ventilated space free of corrosive or explosive fumes, gases, or any combustible material.

(c) Panelboards serving normal lighting and appliance circuits shall be located on the same floor as the circuits they serve. Panelboards for emergency system critical branch and equipment system branch circuits shall be located on each floor that has service requirements. Only panels for emergency system life safety branch circuits may serve floors other than the floor that the panel is located on.

(d) Lighting shall be provided as follows:

- (1) Approaches to buildings and parking lots, and all occupied spaces within buildings shall have fixtures for lighting;

- (2) Patient rooms shall have general lighting and night lighting. A reading light shall be provided for each patient. At least one night light fixture in each patient room shall be controlled at the room entrance. All light controls in patient areas shall be quiet-operating. Lighting for special care bed areas shall permit staff observation of the patient but shall minimize glare;
- (3) Nursing unit corridors shall have general illumination with provisions for reducing light levels at night; and
- (4) Consideration shall be given to controlling lighting intensity to prevent harm to the patients' eyes (i.e., retina damage in premature infants and cataracts due to ultraviolet light).

(e) Receptacles shall be provided as follows:

- (1) Each operating room and delivery room shall have at least eight 120 volt duplex receptacles;
- (2) In areas where mobile X-ray equipment is intended to be used, single receptacles marked for X-ray equipment only shall be installed;
- (3) Neonatal Level I nurseries shall have at least one 120 volt duplex receptacle for each bassinet connected to the normal

electrical service and at least one 120 volt duplex receptacle located on each nursery wall connected to the critical branch of the emergency electrical system;

- (4) Emergency department examination and treatment rooms shall have a minimum of two 120 volt duplex receptacles located convenient to the head of each bed. Trauma rooms shall have a minimum of three 120 volt duplex receptacles convenient to the head of each bed;
- (5) 120 volt duplex receptacles for general use shall be installed 50 feet (15.2 m.) apart in all corridors and within 25 feet (7.6 m.) of corridor ends; and
- (6) Inhalation anesthetizing locations and other areas where patients are intended to have a direct electrical path to the heart muscle shall be equipped with an approved isolated power system as follows:

- (A) The line isolation monitor shall be visible to attending staff while caring for the patient;
- (B) No more than two patients may be served by one isolated power system serving emergency power receptacles;
- (C) Transformers shall not be located over any patient bed location; and
- (D) Branch circuit wiring for isolated power systems shall have a dielectric constant of less than 3.5.

(f) Emergency electrical service shall be provided as follows:

- (1) To provide electricity during an interruption of normal electrical service, a generating set or sets located on the facility site capable of carrying the full emergency load shall be installed;
- (2) Fuel shall be stored on the site in sufficient quantity to provide for not less than 24 hours of operation;
- (3) Where the generator sets are in close proximity to the heating plant, the emergency generator fuel storage capacity may be included in the standby fuel storage tank for the heating burners when the fuels are the same;
- (4) All devices, switches, receptacles, etc., connected to the automatically started generator shall be distinctively identified so that personnel can easily select which device is expected to operate during a failure of the normal source of

power; and

- (5) As a minimum, the following area shall be connected to the essential electrical system:

- (A) Task lighting connected to the critical branch of the emergency system to serve boiler rooms, main switchgear rooms, electrical closets, fire pump rooms, central fire alarm and control rooms, central telephone switchboard room; and
- (B) Heating equipment and associated controls to provide heating for patient care areas shall be connected to the equipment system.

(g) A nurses' calling system shall be provided as follows:

- (1) Each patient room shall be served by at least one calling station for two-way voice communication. Each bed shall be provided with a call device. Two call devices serving adjacent beds may be served by one calling station. Calls shall activate a visible signal in the corridor at the patient's door, in the clean workroom, in the soiled workroom, and at the nursing station of the nursing unit. In multi-corridor nursing units, additional visible signals shall be installed at corridor intersections. In rooms containing two or more calling stations, indicating lights shall be provided at each station. Nurses calling systems at each calling station shall be equipped with an indicating light which remains lighted as long as the voice circuit is operating;
- (2) An emergency calling station shall be provided at each patient-use toilet, bath, sitz bath, and shower. This station shall be accessible to a patient lying on the floor. Inclusion of an approved pull cord will satisfy this standard. The emergency call system shall be designed so that a signal activated at a patient's calling station will initiate a visible and audible signal distinct from the regular nurse calling system that can be turned off only at the patient calling station. The signal shall activate an enumerator panel at the nurse station, and a visible signal in the corridor at the room;
- (3) In areas such as special care where patients are under constant visual



surveillance, the nurses' call system may be limited to a bedside button or station that activates a signal readily seen at the control station; and

- (4) A staff emergency assistance system for staff to summon additional assistance shall be provided in each operating, delivery, recovery, emergency examination or treatment area, and in special care units, nurseries, special procedure rooms, stress-test areas, triage, out-patient surgery admission and discharge areas, and areas for mental patients, including seclusion and security rooms, anterooms and toilet rooms serving them, communal toilet and bathing facility rooms, therapy, exam, and treatment rooms. This system shall announce at the nurse station with back-up to another staffed area from which assistance can be summoned.

Statutory Authority G.S. 131E-79.

## TITLE 12 - DEPARTMENT OF JUSTICE

*Notice* is hereby given in accordance with G.S. 150B-21.2 that the N.C. Alarm Systems Licensing Board intends to adopt rule cited as 12 NCAC 11 .0123.

*The proposed effective date of this action is June 1, 1995.*

*The public hearing will be conducted at 2:00 p.m. on March 8, 1995 at the State Bureau of Investigation Conference Room, 3320 Old Garner Road, Raleigh, N.C. 27626-0500.*

*Reason for Proposed Action:* The Rule sets forth consumer disclosure requirements for those engaged in the alarm systems business. The initial draft of the rule was published in 9:15 NCR 1175. Substantial changes have been made to the rule and the Board has chosen to republish the rule and schedule another public hearing.

*Comment Procedures:* Interested persons may present their views either orally or in writing at the hearing. The Record of Hearing will be open

for receipt of written comments through March 8, 1995. Written comments must be delivered to the Alarm Systems Licensing Board, 3320 Old Garner Road, Raleigh, N.C. 27626-0500.

## CHAPTER 11 - N.C. ALARM SYSTEMS LICENSING BOARD

### SECTION .0100 - ORGANIZATION AND GENERAL PROVISIONS

#### .0123 CONSUMER CONTRACT AND DISCLOSURE REQUIREMENTS FOR ALARM SERVICES

(a) Every person, firm, association or corporation licensed to engage in the alarm systems business in North Carolina who sells, installs, services, responds to or monitors electrical, electronic or mechanical alarm systems shall execute with the consumer a written contract in all transactions that must consist of the following:

- (1) A description of the sale(s) and/or service(s) in brief, simple terminology;
- (2) The company's name, address, telephone number, and North Carolina Alarm Systems License Number and the North Carolina Alarm Systems Licensing Board's address and telephone number.

(b) Any person, firm, association or corporation licensed to engage in the alarm systems business in North Carolina by providing sales, installation, service, response, or monitoring to a consumer and who unilaterally terminates, causes to be terminated or reasonably knows of the termination of the monitoring, response or service to that consumer, shall provide notification to that consumer by verified personal service or certified mail at least 10 days prior to cessation of the service(s). This provision shall not apply to consumer initiated action to terminate or upon consumer relocation.

(c) Any person, firm, association or corporation licensed to engage in the alarm systems business in North Carolina by providing sales, installation, service, response, or monitoring to a consumer and who changes or causes to be changed the monitoring, response or service to that consumer, shall provide written notification to that consumer of the change, the effective date, and the name, address and telephone number of the new provider.

Statutory Authority G.S. 74C-2(a); 74C-5.

**TITLE 15A - DEPARTMENT OF  
ENVIRONMENT, HEALTH, AND  
NATURAL RESOURCES**

*Notice is hereby given in accordance with G.S. 150B-21.2 that the N.C. Wildlife Resources Commission intends to amend rule cited as 15A NCAC 10C .0404.*

*The proposed effective date of this action is July 1, 1995.*

*The public hearing will be conducted at 10:00 a.m. on February 20, 1995 at the Archdale Building, 3rd Floor, 512 N. Salisbury Street, Raleigh, NC 27604-1188.*

*Reason for Proposed Action: To require that gill nets be attended in order to reduce game fish mortality.*

*Comment Procedures: Interested persons may present their views either orally or in writing at the hearing. In addition, the record of hearing will be open for receipt of written comments from February 1, 1995 through March 4, 1995. Such written comments must be delivered or mailed to the N.C. Wildlife Resources Commission, 512 N. Salisbury Street, Raleigh, NC 27604-1188.*

**CHAPTER 10 - WILDLIFE RESOURCES  
AND WATER SAFETY**

**SUBCHAPTER 10C - INLAND FISHING  
REGULATIONS**

**SECTION .0400 - NONGAME FISH**

**.0404 SPECIAL DEVICE FISHING**

(a) Bow and Arrow. The use of bow [as defined in 15A NCAC 10B .0116(a)] and arrow as a licensed special device is authorized for taking nongame fishes at any time from all inland fishing waters other than impounded waters located on the Sandhills Game Land and designated public mountain trout waters. Unless specifically prohibited, bow and arrow may be used in joint fishing waters. It is unlawful to take fish with crossbow and arrow in any inland fishing waters.

(b) Nets. Manually operated nets, including seines and bow, cast, dip, gill, drift and fyke nets may be used under the special device fishing

license.

(1) No fixed gill net or other stationary net which may be authorized as a special fishing device may be more than 100 yards in length, nor shall any such net be placed within 50 yards of any other fixed net. Fixed nets must be set so that they run parallel to the nearest shoreline, except in the Neuse, Trent, North-east Cape Fear, Cape Fear, and Black Rivers and their tributaries. No anchored or fixed gill net or drift net shall be used unless such net is marked for the protection of boat operators. A net shall be deemed so marked when there is attached to it at each end two separate yellow buoys which shall be of solid foam or other solid buoyant material no less than five inches in its smallest dimensions. The owner shall always be identified on a buoy on each end either by using engraved buoys or by attaching engraved metal or plastic tags to the buoys. Such identification shall include one of the following: owner's N.C. motor boat registration number, or owner's U.S. vessel documentation name, or owner's last name and initials.

(2) It is unlawful to attach gill nets to any wire, rope, or similar device extended across any navigable watercourse.

(3) All fixed or drift gill nets must be attended when fished in the designated inland waters of Bertie, Camden, Chowan, Currituck, Dare, Gates, Hertford, Martin, Pasquotank, Perquimans, Tyrrell and Washington counties. Attended as used in this Rule, requires that fishermen be within 100 yards of all sets of nets at all times.

(c) Traps. Baskets and traps, including automobile tires, may be used under the special device fishing license. Such devices when set and left unattended shall be affixed with a card or tag furnished by the license holder and upon which his name and address shall be legibly and indelibly inscribed. No fish trap may exceed 60 inches in length or 30 inches in depth or width. No lead nets, wing nets, or other device designed to guide or herd fish may be attached to the trap or used or set within 25 feet of the trap.

(d) Spears. Manually operated gigs or under-water spear or harpoon guns may be used under the special fishing device license in the



inland waters having a season for their use specified in Rule .0407 of this Section.

(e) Crab pots. Persons owning property adjacent to the inland fishing waters of coastal rivers and their tributaries are permitted to set two crab pots to be attached to their property and not subject to special device license requirements.

*Statutory Authority G.S. 113-134; 113-272.2; 113-276; 113-292.*

*The Rules Review Commission (RRC) objected to the following rules in accordance with G.S. 150B-21.9(a). State agencies are required to respond to RRC as provided in G.S. 150B-21.12(a).*

**COMMERCE**

**Banking Commission**

4 NCAC 3K .0201 - Application for Authorization//Reverse Mortgage Lender	RRC Objection	12/15/94
Agency Revised Rule	Obj. Removed	12/15/94
4 NCAC 3K .0205 - Certificate of Authorization	RRC Objection	12/15/94
Agency Revised Rule	Obj. Removed	12/15/94
4 NCAC 3K .0206 - Nontransferability of Certificate of Authorization	RRC Objection	12/15/94
Agency Revised Rule	Obj. Removed	12/15/94
4 NCAC 3K .0601 - Counseling	RRC Objection	12/15/94
Agency Revised Rule	Obj. Removed	12/15/94

**CORRECTION**

**Division of Prisons**

5 NCAC 2B .0111 - Good Time	RRC Objection	01/19/95
Agency Revised Rule	Obj. Removed	01/19/95
5 NCAC 2B .0112 - Gain Time	RRC Objection	01/19/95
Agency Revised Rule	Obj. Removed	01/19/95
5 NCAC 2B .0113 - Earned Time	RRC Objection	01/19/95
Agency Revised Rule	Obj. Removed	01/19/95

**ENVIRONMENT, HEALTH, AND NATURAL RESOURCES**

**Environmental Health**

15A NCAC 18A .2801 - Definitions	RRC Objection	01/19/95
15A NCAC 18A .2810 - Specifications for Kitchens, Based on Number/Children	RRC Objection	01/19/95

**Environmental Management**

15A NCAC 2Q .0112 - Applications Requiring Professional Engineer Seal	RRC Objection	11/17/94
No Response from Agency	Obj. Cont'd	12/15/94
Rule Returned to Agency	Obj. Cont'd	01/19/95
Agency Filed Rule for Codification Over RRC Objection	Eff.	02/01/95

**General Procedures for Public Health Programs**

15A NCAC 24A .0404 - Reimbursement for Services Not Covered by Medicaid	RRC Objection	12/15/94
RRC Approved Motion to Reconsider	Obj. Cont'd	12/15/94
Rule Returned to Agency	Obj. Cont'd	01/19/95
Agency Filed Rule for Codification Over RRC Objection	Eff.	02/01/95

**Marine Fisheries**

15A NCAC 3I .0017 - Fishery Resource Grant Program	RRC Objection	01/19/95
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<i>Agency Revised Rule</i>	<i>Obj. Removed</i>	<i>01/19/95</i>
<i>15A NCAC 3O .0304 - Consideration of Appeal Petitions</i>	<i>RRC Objection</i>	<i>01/19/95</i>
<i>Agency Revised Rule</i>	<i>Obj. Removed</i>	<i>01/19/95</i>
<b>Wildlife Resources and Water Safety</b>		
<i>15A NCAC 10B .0106 - Wildlife Taken for Depredations or Accidentally</i>	<i>RRC Objection</i>	<i>11/17/94</i>
<i>Agency Revised Rule</i>	<i>Obj. Cont'd</i>	<i>11/17/94</i>
<i>Agency Revised Rule</i>	<i>Obj. Removed</i>	<i>12/15/94</i>
<i>15A NCAC 10G .0206 - Authority of Boat Registration Agents</i>	<i>RRC Objection</i>	<i>01/19/95</i>
<i>Agency Revised Rule</i>	<i>Obj. Removed</i>	<i>01/19/95</i>
<b>HUMAN RESOURCES</b>		
<b>Facility Services</b>		
<i>10 NCAC 3H .0221 - Administrative Penalty Determination Process</i>	<i>RRC Objection</i>	<i>01/19/95</i>
<i>Agency Revised Rule</i>	<i>Obj. Removed</i>	<i>01/19/95</i>
<i>10 NCAC 3T .0102 - Definitions</i>	<i>RRC Objection</i>	<i>01/19/95</i>
<i>Agency Revised Rule</i>	<i>Obj. Removed</i>	<i>01/19/95</i>
<i>10 NCAC 3T .1109 - Resident Care Areas</i>	<i>RRC Objection</i>	<i>01/19/95</i>
<i>Agency Revised Rule</i>	<i>Obj. Removed</i>	<i>01/19/95</i>
<b>Individual and Family Support</b>		
<i>10 NCAC 42C .3601 - Administrative Penalty Determination Process</i>	<i>RRC Objection</i>	<i>01/19/95</i>
<i>Agency Revised Rule</i>	<i>Obj. Removed</i>	<i>01/19/95</i>
<b>Medical Assistance</b>		
<i>10 NCAC 26H .0211 - DRG Rate Setting Methodology</i>	<i>RRC Objection</i>	<i>01/19/95</i>
<i>10 NCAC 26H .0212 - Exceptions to DRG Reimbursement</i>	<i>RRC Objection</i>	<i>01/19/95</i>
<i>Agency Revised Rule</i>	<i>Obj. Removed</i>	<i>01/19/95</i>
<i>10 NCAC 26H .0216 - Cost Reporting and Audits</i>	<i>RRC Objection</i>	<i>01/19/95</i>
<i>Agency Revised Rule</i>	<i>Obj. Removed</i>	<i>01/19/95</i>
<i>10 NCAC 50B .0402 - Financial Responsibility and Deeming</i>	<i>RRC Objection</i>	<i>12/15/94</i>
<i>Agency Revised Rule</i>	<i>Obj. Removed</i>	<i>12/15/94</i>
<b>INSURANCE</b>		
<b>Actuarial Services Division</b>		
<i>11 NCAC 16 .0705 - Claim Reserve Methodology and Actuarial Certification</i>	<i>RRC Objection</i>	<i>01/19/95</i>
<i>Agency Revised Rule</i>	<i>Obj. Removed</i>	<i>01/19/95</i>
<b>Agent Services Division</b>		
<i>11 NCAC 6A .0801 - Definitions</i>	<i>RRC Objection</i>	<i>01/19/95</i>
<i>Agency Revised Rule</i>	<i>Obj. Removed</i>	<i>01/19/95</i>
<i>11 NCAC 6A .0805 - Calculation of 1CECs</i>	<i>RRC Objection</i>	<i>01/19/95</i>
<i>Agency Revised Rule</i>	<i>Obj. Removed</i>	<i>01/19/95</i>
<i>11 NCAC 6A .0808 - Instructor Qualification</i>		
<i>Rule Withdrawn by Agency</i>		<i>01/19/95</i>
<i>11 NCAC 6A .0809 - Approval of Courses</i>		
<i>Rule Withdrawn by Agency</i>		<i>01/19/95</i>

11 NCAC 6A .0811 - Sanctions for Noncompliance  
*Rule Withdrawn by Agency*

01/19/95

**LABOR**

**Boiler and Pressure Vessel**

13 NCAC 13 .0202 - Inspector Qualification	RRC Objection	12/15/94
<i>Agency Revised Rule</i>	Obj. Removed	12/15/94
13 NCAC 13 .0204 - Conflict of Interest	RRC Objection	12/15/94
<i>Agency Revised Rule</i>	Obj. Removed	12/15/94
13 NCAC 13 .0205 - Owner-User Inspection Agency	RRC Objection	12/15/94
<i>Agency Revised Rule</i>	Obj. Removed	12/15/94
13 NCAC 13 .0211 - Certificate Inspections	RRC Objection	12/15/94
<i>Agency Revised Rule</i>	Obj. Removed	12/15/94
13 NCAC 13 .0212 - Preparation for Inspection	RRC Objection	12/15/94
<i>Agency Revised Rule</i>	Obj. Removed	12/15/94
13 NCAC 13 .0213 - Fees	RRC Objection	12/15/94
<i>Agency Revised Rule</i>	Obj. Removed	12/15/94
13 NCAC 13 .0304 - Appeals	RRC Objection	12/15/94
<i>Agency Revised Rule</i>	Obj. Removed	12/15/94
13 NCAC 13 .0402 - North Carolina Stamping and Registration	RRC Objection	12/15/94
<i>Agency Revised Rule</i>	Obj. Removed	12/15/94
13 NCAC 13 .0405 - Safety Valves	RRC Objection	12/15/94
<i>Agency Revised Rule</i>	Obj. Removed	12/15/94
13 NCAC 13 .0411 - Valves, Drains, and Bottom Blowoffs	RRC Objection	12/15/94
<i>Agency Revised Rule</i>	Obj. Removed	12/15/94

**Private Personnel Services**

13 NCAC 17 .0102 - Licensing Procedures	RRC Objection	01/19/95
<i>Agency Revised Rule</i>	Obj. Removed	01/19/95
13 NCAC 17 .0105 - Fee Reimbursement		
<i>Rule Withdrawn by Agency</i>		01/19/95

**LICENSING BOARDS AND COMMISSIONS**

**Commission for Auctioneers**

21 NCAC 4B .0501 - Application for Course Approval		
<i>Rule Withdrawn by Agency</i>		12/15/94
21 NCAC 4B .0502 - Requirements for Approval/Minimum Standards		
<i>Rule Withdrawn by Agency</i>		12/15/94

**Board of Dietetics/Nutrition**

21 NCAC 17 .0113 - Fees	RRC Objection	01/19/95
<i>Agency Revised Rule</i>	Obj. Removed	01/19/95
21 NCAC 17 .0201 - Definitions	RRC Objection	01/19/95
<i>Agency Revised Rule</i>	Obj. Removed	01/19/95
21 NCAC 17 .0202 - Requirement for Review	RRC Objection	01/19/95
<i>Agency Revised Rule</i>	Obj. Removed	01/19/95
21 NCAC 17 .0203 - Review and Board Action	RRC Objection	01/19/95
<i>Agency Revised Rule</i>	Obj. Removed	01/19/95



**Board of Examiners of Electrical Contractors**

21 NCAC 18B .0901 - Applicants Convicted of Crimes	RRC Objection 01/19/95
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**Board of Opticians**

21 NCAC 40 .0314 - Apprenticeship and Internship Requirements; Registration	RRC Objection 11/17/94
Agency Revised Rule	Obj. Cont'd 11/17/94
No Response from Agency	Obj. Cont'd 12/15/94
Agency Responded	Obj. Cont'd 01/19/95

**Board of Professional Engineers and Land Surveyors**

21 NCAC 56 .0502 - Application Procedure: Individual	RRC Objection 11/17/94
Rule Returned to Agency	Obj. Cont'd 12/15/94
Agency Filed Rule for Codification Over RRC Objection	Eff. 01/01/95

**PUBLIC EDUCATION**

**Elementary and Secondary Education**

16 NCAC 6E .0202 - Interscholastic Athletics	RRC Objection 12/15/94
Agency Revised Rule	Obj. Removed 12/15/94

**SECRETARY OF STATE**

**Notary Public Division**

18 NCAC 7 .0103 - Notaries Public Deputy	RRC Objection 12/15/94
Agency Repealed Rule	Obj. Removed 12/15/94
18 NCAC 7 .0301 - Approved Course of Study	RRC Objection 12/15/94
No Response from Agency	Obj. Cont'd 01/19/95
18 NCAC 7 .0302 - Instructors	RRC Objection 12/15/94
No Response from Agency	Obj. Cont'd 01/19/95

**TRANSPORTATION**

**Division of Highways**

19A NCAC 2B .0603 - Driveway Permits for Special Commercial Property	RRC Objection 12/15/94
Agency Revised Rule	Obj. Removed 12/15/94
19A NCAC 2D .0825 - Confidentiality of Cost Estimates and Plan Holder Lists	RRC Objection 01/19/95
Agency Revised Rule	Obj. Removed 01/19/95

*This Section contains the full text of some of the more significant Administrative Law Judge decisions along with an index to all recent contested cases decisions which are filed under North Carolina's Administrative Procedure Act. Copies of the decisions listed in the index and not published are available upon request for a minimal charge by contacting the Office of Administrative Hearings, (919) 733-2698.*

<u>AGENCY</u>	<u>CASE NUMBER</u>	<u>ALJ</u>	<u>DATE OF DECISION</u>	<u>PUBLISHED DECISION REGISTER CITATION</u>
<b>ADMINISTRATION</b>				
<i>North Carolina Council for Women</i>				
Family Violence Prevention Services v. N.C. Council for Women	94 DOA 0242	West	04/13/94	
<b>ALCOHOLIC BEVERAGE CONTROL COMMISSION</b>				
Jerry Lee McGowan v. Alcoholic Beverage Control Comm.	93 ABC 0363	Morrison	08/23/94	
Alcoholic Beverage Control Comm. v. Entertainment Group, Inc.	93 ABC 0719	Gray	03/02/94	
Alcoholic Beverage Control Comm. v. Daehae Chang	93 ABC 0775	Morrison	09/21/94	
Rayvon Stewart v. Alcoholic Beverage Control Commission	93 ABC 0793	Nesnow	04/11/94	
Alcoholic Beverage Control Comm. v. Branchland, Inc.	93 ABC 0892	Morgan	06/03/94	
Alcoholic Beverage Control Comm. v. Peggy Sutton Walters	93 ABC 0906	Mann	03/18/94	
Russell Bernard Speller d/b/a Cat's Disco v. Alcoholic Bev Ctl Comm.	93 ABC 0937	Morrison	03/07/94	
Alcoholic Beverage Control Comm. v. Branchland, Inc.	93 ABC 0993	Morgan	06/03/94	
Edward Ogunjobi, Club Piccadilli v. Alcoholic Beverage Control Comm.	93 ABC 1024	West	03/03/94	
Robert Kovalaske, Nick Pikoulas, Joseph Marshburn, Evangelos Pikoulas, d/b/a Our Mom's BBQ v. Alcoholic Beverage Control Commission	93 ABC 1029	Gray	03/04/94	
Christine George Williams v. Alcoholic Beverage Control Comm.	93 ABC 1057	Becton	04/21/94	
Lynn Ann Garfagna v. Alcoholic Beverage Control Commission	93 ABC 1481	Gray	07/19/94	
Alcoholic Beverage Control Comm. v. Raleigh Limits, Inc.	93 ABC 1485	Mann	03/11/94	
Alcoholic Beverage Control Comm. v. COLAP Enterprises, Inc.	94 ABC 0060	Nesnow	06/07/94	
Alcoholic Beverage Control Comm. v. Mitch's Tavern, Inc.	94 ABC 0064	Gray	07/26/94	
Alcoholic Beverage Control Comm. v. Ms. Lucy Jarrell Powell	94 ABC 0070	Morgan	06/06/94	
Alcoholic Beverage Control Comm. v. Richard Wayne Barrow	94 ABC 0079	Gray	10/14/94	
Alcoholic Beverage Control Comm. v. Subhashbai C. Patel	94 ABC 0083	West	11/01/94	
Alcoholic Beverage Control Comm. v. Daphne Ann Harrell	94 ABC 0115	Nesnow	07/18/94	
Mr. & Mrs. Josh Bullock Jr. v. Alcoholic Beverage Control Comm.	94 ABC 0124	Morgan	06/06/94	
Jerome Crawford v. Alcoholic Beverage Control Commission	94 ABC 0125	Morgan	06/06/94	
Lawrence Mungin v. Alcoholic Beverage Control Commission	94 ABC 0149	Chess	08/08/94	
Willie Poole Jr. v. Alcoholic Beverage Control Commission	94 ABC 0232	Chess	09/02/94	
Alonza Mitchell v. Alcoholic Beverage Control Commission	94 ABC 0257	Morrison	07/28/94	9:11 NCR 870
Roy Dale Cagle v. Alcoholic Beverage Control Commission	94 ABC 0260	West	07/13/94	
Christopher C. Gause, James A Jinwright v. Alcoholic Bev. Ctl. Comm.	94 ABC 0532	Gray	09/27/94	
Rajaddin Abdelaziz v. Alcoholic Beverage Control Commission	94 ABC 0600	Chess	09/22/94	
Alcoholic Beverage Control Comm. v. Sherrie Rena Quick	94 ABC 0717	Gray	12/16/94	
Carol Hewitt v. Alcoholic Beverage Control Commission	94 ABC 0804	Gray	01/04/95	
Alcoholic Bev. Ctl. Comm. v. Partnership, T/A Price Downs Food Mart	94 ABC 0856	West	11/22/94	
Alcoholic Beverage Control Comm. v. Sheila Charlesine Hildebrand	94 ABC 0909	Becton	01/10/95	
Alcoholic Beverage Control Comm. v. James Earl Mullins, Sr.	94 ABC 0934	West	12/05/94	
<b>COMMERCE</b>				
<i>Savings Institutions Division</i>				
James E. Byers, et al v. Savings Institutions	93 COM 1622	Chess	03/01/94	
<b>CORRECTION</b>				
<i>Division of Prisons</i>				
Gene Strader v. Department of Correction	94 DOC 0252	Morrison	03/21/94	



# CONTESTED CASE DECISIONS

<u>AGENCY</u>	<u>CASE NUMBER</u>	<u>ALJ</u>	<u>DATE OF DECISION</u>	<u>PUBLISHED DECISION REGISTER CITATION</u>
<b>CRIME CONTROL AND PUBLIC SAFETY</b>				
Joseph Guernsey & Parents, Robert Guernsey & Dolores Guernsey v. Pitt County Hospital Eastern Radiologists	94 CPS 0413	Gray	07/11/94	
<i>Crime Victims Compensation Commission</i>				
Mae H. McMillan v. Crime Victims Compensation Commission	92 CPS 1328	Morgan	08/11/94	
James Hugh Baynes v. Crime Victims Compensation Commission	93 CPS 0801	West	03/28/94	9:2 NCR 114
Ross T. Bond v. Victims Compensation Commission	93 CPS 1104	West	04/21/94	
James A. Canady v. Crime Victims Compensation Commission	93 CPS 1108	Gray	03/28/94	
Virginia Roof v. Department of Crime Control & Public Safety	93 CPS 1347	Nesnow	03/24/94	
Karen C. Tilghman v. Crime Victims Compensation Commission	93 CPS 1608	Reilly	05/17/94	9:6 NCR 407
Rosemary Taylor v. Crime Victims Compensation Commission	93 CPS 1626	Nesnow	05/25/94	
Violet E. Kline v. Crime Victims Compensation Commission	93 CPS 1670	Morgan	06/13/94	
James Benton v. Crime Victims Compensation Commission	94 CPS 0034	Chess	06/14/94	
Percy Clark v. Crime Victims Compensation Commission	94 CPS 0127	Reilly	04/19/94	
J. Richard Spencer v. Crime Victims Compensation Commission	94 CPS 0157	Chess	06/14/94	
Albert H. Walker v. Crime Victims Compensation Commission	94 CPS 0229	Reilly	08/11/94	
Barbara Henderson v. Crime Victims Compensation Commission	94 CPS 0259	Morrison	04/07/94	
Shirley Handsome v. Crime Victims Compensation Commission	94 CPS 0286	Gray	04/28/94	
Georgeanna Young v. Crime Victims Compensation Commission	94 CPS 0292	Reilly	04/18/94	
Lawrence L. Tyson v. Crime Victims Compensation Commission	94 CPS 0368	Gray	04/26/94	
Ada Battle v. Crime Victims Compensation Commission	94 CPS 0414	Reilly	08/23/94	
Lyman L. Chapman v. Crime Victims Compensation Commission	94 CPS 0415	Chess	06/02/94	
Douglas and Virginia Wilson v. Crime Victims Compensation Comm.	94 CPS 0417	Reilly	06/07/94	
Blanche J. Taylor v. William Hooks Jr., Crime Victims Comp. Comm.	94 CPS 0464	Mann	10/28/94	
Michelle L. Wilcox v. Crime Victims Compensation Commission	94 CPS 0467	Reilly	06/07/94	
Charlie E. McDonald v. Crime Victims Compensation Commission	94 CPS 0468	Gray	09/02/94	9:13 NCR 1056
Lillie Alford/behalf/estate/Venise Alford v. Crime Victims Comp. Comm.	94 CPS 0488	West	11/10/94	
Michael G. Low v. Crime Victims Compensation Commission	94 CPS 0524	Morrison	06/13/94	
Torbit Smith v. Victims Compensation Commission	94 CPS 0535	Becton	10/26/94	
Maureen P. Wilson v. Crime Victims Compensation Commission	94 CPS 0567	Gray	09/23/94	
Kay Thompson Chambers v. Crime Victims Compensation Commission	94 CPS 0581	Morrison	09/28/94	
James R. Gray v. Crime Victims Compensation Commission	94 CPS 0603	Reilly	08/19/94	
Hazel Jarvis v. Victims Compensation Commission	94 CPS 0664	Chess	07/29/94	
Pattie Hale v. Victims Compensation Fund	94 CPS 0734	West	09/06/94	
Dana Harris v. Crime Victims Compensation Commission	94 CPS 0832	Nesnow	09/26/94	
Dorian Walter St. Patrick Scott v. Victims Compensation Comm.	94 CPS 0883	Nesnow	10/04/94	
Susan Cooley v. Crime Victims Compensation Commission	94 CPS 1004	Gray	12/27/94	
In the Matter of the Claim of Claimant: Shirley Robinson Victim: Dandre J. Lamont Offender Charles Fernandez v. Crime Victims Compensation Comm.	94 CPS 1070	Nesnow	12/12/94	
Mary E. Haskins v. Crime Victims Compensation Commission	94 CPS 1406	Gray	03/17/94	
<b>EMPLOYMENT SECURITY COMMISSION</b>				
David Lee Bush v. Employment Security Commission	91 ESC 0395	Reilly	08/18/94	
<b>ENVIRONMENT, HEALTH, AND NATURAL RESOURCES</b>				
Bobby Stallings v. Environment, Health, and Natural Resources	90 EHR 0612	Morgan	08/11/94	
James M. Lyles v. Brunswick County Office of Permits	92 EHR 0333	Chess	09/22/94	
Erby Lamar Grainger v. Environment, Health, & Natural Resources	93 EHR 0071	Reilly	11/22/94	
William P. Shaver, R. McKinnon Morrison III, Jill Ray, Dr. Wesley C. Ray, Douglas W. Furr, Catherine H. Furr & Caldwell Creek Farm, Inc. v. EHNR-State of North Carolina	93 EHR 0452	Morgan	08/11/94	
Ron D. Graham, Suzanne C. Graham v. Robert Cobb, Mecklenburg Cty	93 EHR 1017	Becton	05/31/94	
Robert, Stephanie & Joshua Campbell v. EHNR; Child. Spcl Hlth Svcs	93 EHR 1019	Becton	12/28/94	9:20 NCR 1688
Carnel D. Pearson Jr. v. Craven Co. Division of Health & DEHNR	93 EHR 1759	Mann	09/06/94	
Patricia D. Solomon v. Macon County Health Department	93 EHR 1777	West	05/23/94	
Elbert L. Winslow v. EHNR/Guilford Cty Health Dept. & Guilford Cty Planning & Zoning Board	94 EHR 0086	Chess	07/13/94	
Kathryn A. Whitley v. Macon County Health Department	94 EHR 0088	West	07/13/94	
Brook Hollow Estates v. Environment, Health, & Natural Resources	94 EHR 0093	West	06/03/94	
Laney Oil Company, Inc. v. Environment, Health, & Natural Resources	94 EHR 0098	Nesnow	01/13/95	
Bobby Combs v. Public Water Supply Section	94 EHR 0202	West	10/19/94	

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Oceanfront Court, David C. Gagnon v. Environment, Health, & Nat. Res.	94 EHR 0210	Chess	06/21/94	
Sam's Club #8219 v. Mecklenburg County Health Department	94 EHR 0329	Nesnow	06/15/94	9:7 NCR 496
Everhart & Associates., Inc. and Hettie Tolson Johnson v. Environment, Health, and Natural Resources and Zelig Robinson	94 EHR 0392	Reilly	10/18/94	9:15 NCR 1231
Richard A. Jenkins v. NC Water Pollution Ctl. Sys. Op. Cert. Comm.	94 EHR 0424	West	10/11/94	
Eugene Crawford & Nancy P. Crawford v. Macon County Health Dept.	94 EHR 0500	Gray	06/10/94	
Joseph B. Leggett v. Environment, Health, & Natural Resources	94 EHR 0560	West	09/21/94	
Tri-Circuits, Inc. v. Environment, Health, & Natural Resources	94 EHR 0601	Morrison	06/30/94	
Thomas Taylor Fain v. Martin-Tyrrell-Wash. Dist. Health Dept., EHNR	94 EHR 0736	West	11/22/94	
Marlen C. Robb, Jr. v. CAMA, Washington, NC EHNR	94 EHR 0767	West	11/22/94	
Irene, Will, Eric Litaker v. Montgomery County Health Department	94 EHR 0776	Gray	09/06/94	
James Loder v. New Hanover Inspection Svcs., Local CAMA Permit Off.	94 EHR 0821	Chess	11/21/94	
National Food Market v. Environment, Health, and Natural Resources	94 EHR 0998	Reilly	12/19/94	
<i>Coastal Management</i>				
Roger Fuller v. EHNR, Div. of Coastal Mgmt & Environmental Mgmt	89 EHR 1378*	Gray	04/07/94	
Roger Fuller v. EHNR, Div. of Coastal Mgmt & Environmental Mgmt	90 EHR 0017*	Gray	04/07/94	
John R. Hooper v. EHNR, Div./Coastal Mgmt & Bird's Nest Partnership	90 EHR 0455	Morgan	08/11/94	
Gary E. Montalbino v. Division of Coastal Management	93 EHR 1792	Nesnow	03/21/94	
Paley-Midgett Partnership v. Coastal Resources Commission	94 EHR 0315	Gray	06/01/94	
<i>Craven County Health Department</i>				
Cox Transport Equipment, Harvey A Cox v. County of Craven, EHNR	94 EHR 0487	West	11/01/94	
<i>Environmental Health</i>				
Jane C. O'Malley, Melvin L. Cartwright v. EHNR & District Hlth Dept Pasquotank-Perquimans-Camden-Chowan	91 EHR 0838	Becton	04/06/94	
Henry Lee Bulluck v. Nash County Health Department & EHNR	93 EHR 0348	Morgan	07/22/94	
Environment, Health, & Natural Res. v. Clark Harris & Jessie Lee Harris	93 EHR 0924	Becton	03/03/94	
Richard F. Ebersold v. Jackson County Health Department & EHNR	93 EHR 1391	Chess	06/24/94	
Crab Shack Restaurant v. EHNR, Div. of Environmental Health	93 EHR 1609	Gray	12/27/94	
Sidney S. Tate Jr. v. Dept. of Environment, Health, & Natural Resources	94 EHR 0005	Reilly	05/24/94	
George A Waugh, Shirley A. Waugh v. Carteret Cty Health & Env. Hlth	94 EHR 0128	Chess	07/13/94	
Scotland Water Co., Laurin Lakes v. Environment, Health, & Nat. Res.	94 EHR 0200	Nesnow	04/27/94	
H.A. Lentz v. Department of Environment, Health, & Natural Resources	94 EHR 0235	Nesnow	07/19/94	
Floyd Benn Williams v. Dept. of Environment, Health, & Nat. Res.	94 EHR 0333	Reilly	05/18/94	
Robert Leon Snipes v. Environmental Health, Hillsborough NC	94 EHR 0529	Morrison	01/04/95	
Ralston Pound, Jr. & Deanie S. Pound v. Carteret Cty. Env. Health Dept.	94 EHR 1003	Reilly	12/07/94	
<i>Environmental Management</i>				
David Springer v. Dept. of Environment, Health, & Natural Resources	92 EHR 1797	Morgan	05/19/94	
Petroleum Installation Equipment Co., Inc. v. Env., Health & Nat. Res.	93 EHR 0531	Chess	03/21/94	
Howell's Child Care Center, Inc. v. EHNR, Div of Environmental Mgmt.	93 EHR 0955	West	11/02/94	
Spring Valley Meats, Inc. v. Environment, Health, & Natural Resources	93 EHR 0974	West	11/03/94	
Jack Griffin v. Dept. of Environment, Health, and Natural Resources	93 EHR 1030	Becton	03/21/94	
Wooten Oil Company v. EHNR, Div of Environmental Management	94 EHR 0001	West	09/30/94	
John G. Owens & J.B.S. Mechanical Svcs, Inc. v. EHNR, Env. Mgmt.	94 EHR 0024	Mann	09/07/94	
General Electric Co., Inc. v. EHNR, Env. Mgmt. Comm. & City/Mebane	94 EHR 1031	Reilly	11/30/94	9:19 NCR 1595
<i>Land Resources</i>				
Wallace B. Clayton, Dr. Marshall Redding v. Div. of Land Resources	93 EHR 1407	Morgan	08/09/94	
Town of Kernersville (LQS 93-053) v. Environment, Health, & Nat. Res.	93 EHR 1781	Chess	06/29/94	9:8 NCR 581
Royce Perry, Paul Perry v. Dept. of Environment, Health, & Natural Res.	94 EHR 0525	Gray	07/01/94	
<i>Marine Fisheries</i>				
Robert I. Swinson, Virginia S. Swinson v. EHNR, Div/Marine Fisheries	93 EHR 0394	Gray	04/11/94	
Larry J. Batson v. Division of Marine Fisheries	93 EHR 0857	Morgan	07/22/94	
David W. Oglesby v. Division of Marine Fisheries	93 EHR 0930*	West	07/25/94	9:10 NCR 758
David E. Oglesby v. Division of Marine Fisheries	93 EHR 0931*	West	07/25/94	9:10 NCR 758

\* Consolidated Cases.



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James Goodman v. EHNR, Division of Marine Fisheries	94 EHR 0035	Nesnow	07/18/94	9:9 NCR 660
Billy Ervin Burton v. Division of Marine Fisheries	94 EHR 0504	Nesnow	09/01/94	
<b>Maternal and Child Health</b>				
<b>WIC Section</b>				
Anthony Awueah v. EHNR, Div. Maternal & Child Health, WIC Section	94 EHR 0718	Chess	09/23/94	
Orange Finer Food v. Environment, Health, and Natural Resources	94 EHR 0965	Reilly	12/19/94	
Salah Helu v. Environment, Health, and Natural Resources	94 EHR 0976	Reilly	12/20/94	
<b>Solid Waste Management</b>				
Roger Sessoms v. EHNR/Asbestos Hazard Management Branch	93 EHR 0951	Gray	03/28/94	
Bertie Citizens Action Coalition, Inc.; Willard J. Oliver, Reginald Early, Herbert Jenkins, Jr., Lindwood Earl Tripp, Willie Warren Tripp, Mary Alice Cherry, and Kathy Burden v. EHNR, Solid Waste Management Division, and East Carolina Environmental, Inc., Addington Environmental, Inc., et al.	93 EHR 1045	Morrison	04/06/94	9:3 NCR 214
Bobby Benton v. EHNR & Division of Solid Waste	94 EHR 0442	Gray	08/22/94	
<b>HUMAN RESOURCES</b>				
Jerome Triplin v. Department of Human Resources	93 DHR 0108	Reilly	08/19/94	
Helen J. Walls, Walls Young World v. Department of Human Resources	93 DHR 0965	Morgan	08/11/94	
Brenda C. Robinson v. Department of Human Resources	94 DHR 0365	West	06/01/94	
Betty King v. Department of Human Resources	94 DHR 0439	Chess	12/15/94	
Betty Rhodes v. Department of Human Resources	94 DHR 0501	Morrison	06/02/94	
Mr. & Mrs. Richard Bullen v. Department of Human Resources	94 DHR 0811	Becton	11/14/94	
<b>Distribution Child Support</b>				
Mona L. Stanback v. DHR, Div/Social Svcs, Child Support Enf. Section	93 DCS 0969	Morgan	08/02/94	
Jachell D. Parker v. Department of Human Resources	93 DCS 0371	Morgan	07/14/94	
Earleen G. Tinsley v. Department of Human Resources	94 DCS 0651	Nesnow	09/15/94	
<b>Division of Child Development</b>				
Judith Fridley v. Div. of Child Development/Abuse/Neglect Unit	93 DHR 0973	Morrison	03/08/94	
DHR, Division of Child Development v. Joyce Gale	93 DHR 1344	Gray	04/28/94	
Laureen Holt, ID#26-0-00037 v. DHR, Div. of Child Development	93 DHR 1549	Becton	07/13/94	
Gloria C. Haith v. Department of Human Resources	93 DHR 1707	Nesnow	03/22/94	
Gloria C. Haith v. Daycare Consultant	93 DHR 1787	Nesnow	03/14/94	
Charles E. Smith v. Department of Human Resources	93 DHR 1797	Nesnow	03/21/94	
Scott's Loving Day Care & Nursery, Mrs. Willie L. Scott v. DHR	94 DHR 0106	Nesnow	06/29/94	
Belinda K. Mitchell v. Human Resources, Div. of Child Development	94 DHR 0119	Reilly	06/30/94	
Living Word Day Care, Jonathan Lankford v. Dept. of Human Resources	94 DHR 0168	Nesnow	03/23/94	
David G. Whitted, Pres., Toddlers Academy, Inc. v. Div of Child Dev.	94 DHR 0453	Mann	09/23/94	
Miriam C. Kircher v. Human Resources, Div. of Child Development	94 DHR 0615	Morrison	11/17/94	
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<b>Facility Services</b>				
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Presbyterian-Orthopaedic Hospital v. Department of Human Resources	93 DHR 0805	Reilly	03/11/94	
Judy Hoben Wallace v. Department of Human Resources	93 DHR 0935	Gray	05/23/94	
Lowell Stafford v. Department of Human Resources	93 DHR 1381	Gray	04/15/94	
Willie J. McCombs v. Human Resources, Div. of Facility Services	94 DHR 0430	Gray	09/29/94	
Mr. & Mrs. Alvin Wilson v. DHR, Division of Facility Services	94 DHR 0559	Chess	08/25/94	
Steve Alan Russell v. DHR, Div. of Facility Svcs, Emergency Med. Svcs	94 DHR 0830	Gray	11/28/94	
Bettie Graham v. Youth and Family Services, Charlotte, N.C.	94 DHR 1527	Gray	01/04/95	
<b>Certificate of Need Section</b>				
Charles E. Hunter, Jr., M.D. & Coastal Perfusion Svcs, Inc. v. Department of Human Resources, and Wilmington Perfusion Corp. and Howard F. Marks, Jr., M.D.	93 DHR 0746	Morgan	04/11/94	
Cape Fear Memorial Hospital v. Department of Human Resources	93 DHR 1552	Reilly	08/15/94	

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Angel Community Hospital, Inc. v. DHR, Div. of Facility Svcs., Cert./ Need Section, and Brithaven, Inc., d/b/a Brithaven of Franklin	94 DHR 0146	West	10/21/94	
The Carrolton of Fayetteville, Inc. v. Department of Human Resources and	94 DHR 0197*	Morgan	08/11/94	
Highland House of Fayetteville, Inc. & Richard R. Allen Sr. v. DHR The Carrolton of Fayetteville, Inc. v. Department of Human Resources and	94 DHR 0198*	Morgan	08/11/94	
Highland House of Fayetteville, Inc. & Richard R. Allen Sr. v. DHR ABC Home Health Services, Inc. v. Human Resources, Div. of Facility Services, Certificate of Need Section v. Mecklenburg Home Health, Inc., d/b/a Home Health Professionals of Guilford	94 DHR 0254	Morrison	11/17/94	
Professional Nursing Services, Inc. and Betty Wallace v. Certificate of Need Section, Div. of Facility Services, Human Resources and	94 DHR 0609	West	11/21/94	
Duplin Home Care & Hospice, Inc.; Hometown Hospice, Inc.; Craven County Health Dept. Home Health-Hospice Agency; Hospice of Pamlico County, Inc.; Hospice of Carteret County; and Comprehensive Home Health Care I, Inc.				
<i>Division of Medical Assistance</i>				
J.R., by and through her agent & Personal Rep., Hank Neal v. DHR	93 DHR 0528	Gray	04/27/94	
N.R. by & through her agt & personal rep E.C.J. v. DHR, Medical Assis.	93 DHR 0538	Chess	07/01/94	
David Yott v. Department of Human Resources	93 DHR 1113	Gray	04/05/94	
Sampson County Memorial Hospital v. DHR, Div of Medical Assistance	93 DHR 1760	West	09/07/94	
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Lu Ann Leidy, MD/Dorothea Dix Hosp. Child & Youth v. Medical Assis.	94 DHR 0448	Chess	06/21/94	
<i>Division of Social Services</i>				
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Dalton Felton Sr. v. Department of Human Resources	92 CSE 0532	Morgan	07/13/94	
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Vicki C. Conn v. Department of Human Resources	92 CSE 1268	Morgan	08/10/94	
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Thomas Sadler v. Department of Human Resources	92 CSE 1739	Becton	10/18/94	
Nancy Richardson v. Department of Human Resources	93 CSE 0180	Chess	11/22/94	
Frederick C. Burdick Jr. v. Department of Human Resources	93 CSE 0227	Mann	11/09/94	
Darryl D. Leedy v. Department of Human Resources	93 CSE 0591	Morgan	08/11/94	
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Sherman E. Ames v. Department of Human Resources	93 CSE 1137	Chess	11/09/94	
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Anthony A. Macon v. Department of Human Resources	93 CSE 1149	Gray	04/26/94	



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Alvin M. Davis v. Department of Human Resources	93 CSE 1152	Morgan	08/04/94	
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Quinton Brickhouse v. Department of Human Resources	93 CSE 1179	Gray	01/05/95	
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**V.**

**N.C. A&T STATE UNIVERSITY,  
Respondent.**

## RECOMMENDED DECISION

J. Sam Johnson, Jr. represented the petitioner. Anne J. Brown represented the respondent. The petitioner testified and introduced Exh. #1, 2, 3 and 4. The respondent presented fourteen witnesses and introduced Exh. #7, 12, 15, 16, 17, 18, 19, 20, 21, 23, 24, 25, 25A, 29, 32, 34, 35, 36, 39, 40 and 41. The petitioner filed a Written Argument on September 19, 1994. Due to delay in preparing the transcript, the respondent was not able to file Proposed Findings of Fact until December 29, 1994.

1. Did the respondent have just cause to dismiss the petitioner?
2. Did the respondent, in dismissing the petitioner, discriminate and retaliate against her on the basis of race?

1. The petitioner, a white woman and registered nurse, was employed as a staff nurse in the Sebastian Health Center from 1977 until November 3, 1993. She was the only white nurse.
2. The petitioner received the following disciplinary warnings:

Verbal warning, August 18, 1987  
Written warning, January 16, 1987  
Written warning, November 23, 1988  
Final written warning, March 28, 1990  
Written warning, August 2, 1990  
Written warning, November 5, 1992  
Verbal warning, April 5, 1993  
Final warning, May 19, 1993  
Written warning, October 21, 1993

3. During a conference on November 3, 1993, Linda Bowling, a black woman and the petitioner's supervisor, asked the petitioner whether she had destroyed the original assessment form of Angela Thomas, a student and employee of Taco Bell who had come to the health center for treatment for a cut on her hand. She further asked whether the petitioner understood the proper way to make a change in a medical record. Ms. Bowling handed the petitioner an excerpt from a reference book maintained in the department that explained how to correct errors and make changes in medical

records. The petitioner had replaced the original form with another. The petitioner had not been told to destroy the original form which Dr. Flotilla Watkins had signed.

4. The petitioner admitted that she destroyed Ms. Thomas' original assessment form and then prepared another form to correct her errors on the first form. Ms. Bowling then informed the petitioner that a predissmissal conference was being conducted. No advance notice of the conference or the reasons for the conference was given. The petitioner had noticed a security guard outside of Ms. Bowling's office when she entered. She had been summoned to the office upon reporting for work. Dr. James Sibert was in the office with Ms. Bowling. Dr. Sibert and Ms. Bowling did not confer to consider the petitioner's responses. Rather, Ms. Bowling concluded the predissmissal conference by stating:

Considering the fact that you destroyed this chart, this old assessment form, I have no other recourse but to fire you. (T p 189, Vol. III)

After the conference, the security guard took the petitioner by the arm and escorted her to her car.

5. A dismissal letter was issued on the same day. The letter gave the following reasons for dismissal:

Personal conduct as it relates to your removal of and/or destruction of and/or falsification of medical records relating to the visit of Angela Thomas in the Health Center on October 20, 1993.

For compromising the integrity of this student's medical records.

6. The petitioner did not falsify any medical records. The integrity of Ms. Thomas' medical record was compromised in that destruction of the original assessment form creates uncertainty about what care had been administered to Ms. Thomas.
7. The petitioner had received training at the health center concerning the proper way to correct an error in a medical record. A copy of the nursing policy and procedure relating to charting and documentation is maintained at the nurses desk at the Sebastian Health Center. "The person correcting a charting error should cross out the incorrect entry, enter the correct information, initial the correction and enter the time and date the correction was made. . . ." R Exh. 34, p 1
8. Clara Smith, an expert in the field of nursing testified that, in her opinion, a registered nurse should know that it is improper to destroy a patient's medical record.
9. Ms. Bowling did not make the comment, "I don't know why with so many good black nurses, we have a white nurse on the staff."
10. The petitioner's shift assignment was not changed because of race, as alleged by the petitioner, but rather as a result of an incident for which petitioner received a final written warning. The petitioner's shift assignment was changed to the day shift in order for her to receive close supervision in performing assessments.
11. Ms. Bowling did not retaliate against the petitioner by not allowing her to go on a retreat. Rather, she made arrangements for the petitioner to attend the retreat. The petitioner decided not to attend the retreat.

### **CONCLUSIONS OF LAW**

1. The petitioner was a permanent State employee at the time of her dismissal.
2. "(N)o permanent employee subject to the State Personnel Act shall be dismissed, except for just cause." See G.S. 126-35. Just cause may be substantive or procedural. Substantive just cause falls into two categories:



- (1) causes relating to performance of duties (prior warnings are required); and
- (2) causes relating to personal conduct detrimental to State service (no prior warnings are required).

3. In Jones v. Department of Human Resources, 300 NC 687, 690-691, 268 SE2d 500, 502 (1980), the Supreme Court of North Carolina held that "(p)rior to dismissal for causes relating to performance of duties, a permanent State employee is entitled to three separate warnings that his performance is unsatisfactory."
4. The respondent had substantive just cause to dismiss the petitioner. The just cause related to performance of duty, i.e. the failure to properly correct errors in medical records. The petitioner had received the required prior warnings. The petitioner did not engage in conduct detrimental to State service. Although the dismissal letter characterized the reason as personal conduct, the evidence establishes both the required prior warnings and deficiencies in job performance.
5. The petitioner has failed to establish that she was terminated from employment because of her race and that she was retaliated against for complaining about discrimination.
6. The predissmissal conference did not comply with 25 NCAC 1J .0606. The respondent violated the petitioner's procedural due process rights which include an opportunity to present her position in a meaningful time and manner. Dr. Sibert and Ms. Bowling had decided to dismiss the petitioner before the predissmissal conference. Although the issue involved record-keeping, a guard was posted at the office door for the purpose of escorting the petitioner to her car after she was dismissed.
7. The petitioner is entitled to an award of back pay from the date of the dismissal (November 3, 1993) through the date of the hearing (July 26, 1994). The petitioner is also entitled to an award of attorney's fees. See 25 NCAC 1B .0432(c) and G.S. 126-4(11). See also Bishop v. Department of Human Resources, 100 NC App 175, 394 SE2d 702 (1990), disc. rev. improvidently allowed, 328 NC 325, 401 SE2d 366 (1991).

#### RECOMMENDED DECISION

It is recommended that the petitioner's dismissal be upheld but that the petitioner be awarded back pay and attorney's fees for the procedural violations.

#### NOTICE

The parties have the right to file exceptions and to present written arguments to the State Personnel Commission. The final decision in this contested case shall be made by that agency. The agency will mail a copy of the final decision to the parties and the Office of Administrative Hearings.

This the 6th day of January, 1995.

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Robert Roosevelt Reilly Jr.  
Administrative Law Judge

*The North Carolina Administrative Code (NCAC) has four major subdivisions of rules. Two of these, titles and chapters, are mandatory. The major subdivision of the NCAC is the title. Each major department in the North Carolina executive branch of government has been assigned a title number. Titles are further broken down into chapters which shall be numerical in order. The other two, subchapters and sections are optional subdivisions to be used by agencies when appropriate.*

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