# RULES AND REGULATIONS

## Title 28—HEALTH AND SAFETY

### DEPARTMENT OF HEALTH

### [28 PA. CODE CHS. 201, 203, 205, 207, 209 AND 211]

### Long-Term Care Nursing Facilities

*Scope and Purpose*

This final rulemaking amends Part IV (relating to health facilities) by amending Subpart C (relating to long-term care facilities), Chapters 201, 203, 205, 207, 209 and 211, to read as set forth in Annex A.

The Health Care Facilities Act (act) (35 P. S. §§ 448.101—448.904) provides that, to be issued a license as a health care facility, an applicant shall show that: 1) it is a responsible entity; 2) the place to be used as a health care facility is adequately constructed, equipped and maintained, and safely and efficiently operated; 3) it will provide safe and efficient services adequate for the care and treatment of patients or residents; and 4) it is in substantial compliance with the rules and regulations of the Department of Health (Department). See section 808(a) of the act (35 P. S. § 448.808(a)).

The vast majority of long-term care nursing facilities (facilities) in this Commonwealth participate in the Federal Medicare and Medicaid programs. The Department is the State survey agency for the Health Care Financing Administration (HCFA) and, as such, surveys facilities for Federal certification as well as State licensure purposes. Facilities which participate in the Medicare and Medical Assistance (MA) Programs must comply with the Federal certification regulations in 42 CFR 483.1—483.75 (relating to requirements for long-term care facilities), as well as the State licensure regulations in Part IV, Subpart C.

The Federal regulations address many of the same areas addressed by the facility licensure regulations in Part IV, Subpart C. In certain instances the State licensure and Federal certification regulations are duplicative. In other cases, the two sets of regulations conflict. In an effort to resolve the inconsistencies and unnecessary duplication, the Department is adopting many of the Federal regulatory provisions and incorporating them into its State licensure regulations. Further, the Department has deleted those State licensure regulations which were overly prescriptive, but has kept those regulations which the Federal certification regulations either do not address or are less specific than the licensure regulations.

The Department felt it necessary, for public protection purposes, to keep certain State licensure regulations which are not addressed in the Federal certification regulations. For example, there is no Federal counterpart to the State licensure regulation in § 211.1 (relating to reportable diseases), requiring the reporting of specific diseases, or to § 201.22 (relating to prevention, control and surveillance of tuberculosis (TB)), pertaining to the protocols for tuberculosis control.

There are a few amendments to current regulations which are stricter in some respects than the corresponding Federal regulations. For example, the Federal regulation in 42 CFR 483.13(a) (relating to resident behavior and facility practices) states that a restraint may not be applied for discipline or convenience. The State licensure regulation pertaining to restraints in § 211.8 (relating to use of restraints) has always been more specific than the Federal regulation. The Department has now added a requirement that the need for a restraint be reviewed every 30 days by an interdisciplinary team as defined in § 201.3 (relating to definitions). Another amendment in § 201.3 revises the definition of "restraint" to include chemical as well as physical restraints. This follows the Federal regulations.

The State licensure regulation in § 201.14 (relating to responsibility of licensee) lists various incidents that must be reported to the appropriate Division of Nursing Care Facility field office. The proposed amendments add deaths due to sepsis as a reportable incident and require notification within 24 hours.

With regard to transfers and discharges, both State and Federal regulations provide that they shall be appropriate and may occur only after adequate prior notice. However, the amendment in § 201.29(d) (relating to resident's rights) specifically places the responsibility for appropriate placement on the facility.

The regulations will provide consistency for the majority of facilities that participate in the Federal reimbursement programs and will offer additional protection to residents of this Commonwealth by retaining important State licensure provisions that are not fully addressed by the Federal certification regulations.

*Public Comments*

Notice of proposed rulemaking was published at 27 Pa.B. 3609 (July 19, 1997) with an invitation to submit written comments within 30 days. Within the 30 day comment period, the Department received letters with comments from 36 individuals or organizations having an interest in long-term care. The Department also received comments from Senator Allen Kukovich and former Senator Hardy Williams, and Representatives Mike Veon, Patricia Vance, Keith McCall and James Casorio. The Department of Aging and Department of Public Welfare submitted comments as well. Finally, the Independent Regulatory Review Commission (IRRC) provided the Department with comments to the proposed rulemaking.

The following is a discussion of the comments received and the Department's response to those comments:

*Chapter 201. Applicability, Definitions, Ownership and General Operation of Long-Term Care Nursing Facilities*

*Section 201.2. Requirements.*

The Department received various comments with respect to the proposed amendment of this section to incorporate Subpart B of the Federal long-term care certification regulations, 42 CFR 483.1—483.75, into the State licensure regulations, with certain specific exceptions. In light of comments received, the Department has removed several exceptions in the proposed regulations. The exceptions which the Department has decided to not incorporate primarily reference the Medicare and Medicaid programs and are thus applicable to the facilities which participate in those programs only and not suitable as general licensure regulations.

Several commentators, including the Pennsylvania Association of Non Profit Homes for the Aging (PANPHA), the Pennsylvania Health Care Association (PHCA), the Pennsylvania Association of County Homes Affiliated

Homes (PACAH), former Senator Williams and IRRC, suggested that the Department should adopt the Federal nurse aide training requirement in 42 CFR 483.75(e) (relating to administration), which provides for each state to operate a nurse aide registry and requires a state approved training and competency evaluation for nurse aides that meets the requirements of 42 CFR 483.151—483.154.

The Department currently operates the nurse aide registry for the Commonwealth. The majority of facilities require Federal certification and thus must use the registry and trained nurse aides. However, the Department agrees with the commentators that it should adopt the Federal regulation as a State requirement as well, to ensure that facilities in this Commonwealth, including those that do not participate in the Medicare or MA Programs, hire only trained nurse aides who have passed a competency evaluation and are in good standing on the registry. Therefore, the Department has adopted the Federal regulation in 42 CFR § 483.75(e) as a requirement of State licensure, by excluding it from the proposed list of exceptions.

The PANPHA asked why the Department was not adopting the Minimum Data Set (MDS) required by the Federal regulation in 42 CFR 483.20(b)(1)(i) (relating to resident assessment). Following the implementation of the case-mix reimbursement system, the Department added a new Pennsylvania-specific section to the MDS. Therefore, the Department has determined that it should adopt the MDS requirement for state licensure purposes as a quality improvement initiative. It has excluded that regulatory requirement from the proposed list of exceptions.

The Department agrees with a comment from former Senator Williams that it should adopt the Federal regulation in 42 CFR 483.10(c)(3)(i) (relating to level A requirement: Resident rights), which requires a facility to deposit residents' personal funds in excess of $50 in an interest bearing account separate from the facility's operating accounts. Although the current licensure regulation in § 201.18 (relating to management) does not require that resident funds be placed in an interest bearing account, the Department concludes that this should be a requirement for all Commonwealth facilities. Therefore, the Department has decided it will adopt 42 CFR 483.10(c)(3) so that all facilities in this Commonwealth, and not just those which participate in the Medicare or MA Programs, will be required to place residents' funds in excess of $50 in an interest bearing account. However, the Department has determined that it will not adopt the surety bond requirement in 42 CFR 483.10(c)(7) as a State licensure requirement.

The PANPHA and former Senator Williams questioned why the Department was not adopting the Federal regulatory requirement in 42 CFR 483.70(d)(1)(iv) (relating to physical environment) requiring full visual privacy. The exception in § 201.2 (relating to exceptions) in the proposed regulations was a typographical error. It is now corrected to read 42 CFR 483.70(d)(1)(v), which requires privacy curtains only in facilities initially certified after March 3, 1992. The Department interprets the requirement of full visual privacy to mean all beds shall have privacy curtains.

Several commentators, including the Department of Aging and former Senator Williams, expressed concern regarding the format of the regulations and expressed their desire to see the text of the Federal regulations adopted rather than the regulatory citation alone. The Department does not consider it necessary to include the specific Federal language for purposes of official legal publication in the *Pennsylvania Bulletin* and the *Pennsylvania Code*. The Department currently provides regulation manuals upon request. It will ensure that those manuals integrate the Federal regulatory sections being adopted, and it will make them available to providers and the public in a user-friendly format.

The Department had proposed to revise the exception provision in former § 201.2 and move it to the general administrative Chapter 51 (relating to general information). Several commentators did not realize that this was the case and expressed concern that the exception provision had been deleted. The exception provisions are now applicable to all health care facilities and appear in §§ 51.33 and 51.34 (relating to requests for exceptions; and revocation of exceptions).

*Section 201.3. Definitions.*

*Abuse*

Section 201.3 is amended to include a new definition of "abuse." The definition is taken from the guidelines to the Federal regulations. This is also the definition of "abuse" which is used by the Department when adjudicating appeals by nurse aides who have had a finding of abuse entered against them in the nurse aide registry. The Department kept that portion of the former definition which now appears under the subheading of "neglect."

IRRC, the PANPHA and PACAH commented that the Department should adopt the definition of abuse in the Older Adults Protective Services Act (35 P. S. §§ 10225.101—10225.5102) (Act 79), rather than the language in the federal guidelines. The definition of abuse in Act 79 is included in the language proposed by the Department except that the definition of sexual abuse in Act 79 refers to the definition of sexual abuse in the Protection From Abuse Act (PFA). The Department felt that the definition of sexual abuse in the PFA deals more with sexual abuse among family members and was not as relevant as the description of what constitutes sexual abuse in the Federal abuse guidelines.

IRRC also commented that the Department should include the statutory definition of "abandonment." The Department has decided not to include a separate definition of abandonment as the definition of "neglect" covers that concept. This definition states that neglect includes deprivation by a caretaker of goods or services which are necessary to maintain physical or mental health.

The Department concludes that the definition of "abuse" in the Federal abuse guidelines is more explicit and includes most of the definition in Act 79. Also, the Department's definition of "abuse" specifically states that it applies to all residents, including those who are not necessarily competent or conscious. Further, to remain consistent with its investigations and prosecutions of nurse aides accused of abusing residents, the Department feels it is important to adopt the language in the Federal guidelines.

The proposed rulemaking would have added the requirement that the abuse be "willful." The Department has removed this term since this is not part of the Federal language. The Department agrees with recommendations from IRRC and Cedarbrook Nursing Homes that this qualifier be removed as it would make it much more difficult to prosecute an alleged abuser.

The PHCA and Extendicare expressed their concern that the definitions of "abuse" and "neglect" do not take

into consideration the fact that services may be withheld at the request of a resident such as in an advance directive. They recommended that this be clarified in the definitions. A living will or other advance directive would be part of a resident's clinical record and as such would be readily available for review by surveyors if a question would arise as to whether withholding particular care or therapy constituted neglect. The Department, therefore, does not choose to incorporate this exception into the definitions.

*Activities Coordinator*

In response to a comment by the PANPHA, pointing out that § 211.17 (relating to patient activities) would be deleted with the exception of the provisions dealing with pet therapy, the Department has deleted the definition of "activities coordinator." This term will no longer appear in the regulations.

*Charge nurse*

The definition of "charge nurse" was revised as proposed. The Department received a comment from the PNA that this term was outdated in the health care industry. However, as it is used in many nursing facilities, the Department has not changed the heading of charge nurse. It has, however, updated the requirements for being a charge nurse.

*Clinical records*

The PANPHA and IRRC commented that the proposed definition of "clinical records" was too broad and could require the release of more than just the resident's medical record. The proposed definition was based on the Federal interpretation of the term. However, in response to the comment, the Department deleted the portion of the proposed definition that included records dealing with social records and resident fund accounts.

*Dietitian*

The proposed rulemaking included a revised definition of "dietitian" to require that a person who would serve as a dietitian would have either registration by the Commission on Dietetic Registration of the American Dietetic Association, or appropriate education, training or experience. A dietitian and IRRC suggested that the Department specify what appropriate education, training or experience is. Therefore, the Department has revised the definition to specifically include those requirements which make one eligible for registration by the Commission.

*Dietetic service supervisor*

In response to a suggestion by the PANPHA the Department deleted the word "qualified" before "dietitian" in the definition of "dietetic service supervisor" as the qualifications for a dietitian are in the definition of that term.

*Elopement*

The Department is adding a definition of "elopement" in this section and taking the definition out of § 201.14 (relating to responsibility of licensee). The PACAH had raised a specific comment with regard to the requirement of reporting elopements in § 201.14, arguing that elopement should be limited to incapacitated residents who are missing from the facility for over 1 hour. The PANPHA suggested a definition that would limit elopements to residents who have wandered off the facility's premises and whose whereabouts are unknown. The Department rejected this recommendation. It determined that the definition of "elopement" should apply to all residents who are missing and not be limited to those who have wandered off the premises. Further, the Department does not believe the reporting requirement should be triggered by a specific period of time that the resident is missing.

The facility's premises could encompass many acres of surrounding land owned by the facility. Residents who elope are at risk of injury or death. There have been instances of these occurrences in the past. Therefore, the Department is more comfortable with a comprehensive definition which would require reporting when a resident leaves the facility itself without the facility's knowledge. This strict definition is not intended, however, to restrict the freedom of movement of those residents who are competent and generally permitted outside on facility grounds.

*Existing facility*

IRRC, the PANPHA and PHCA commented that the Department should revise this definition to reflect that an existing facility is a facility constructed and licensed before the effective date of these regulations. The Department agrees.

*Experimental Drug*

The Department agrees with a suggestion made by IRRC that it delete the definition of "experimental drug" as it is deleting § 211.9(p)(relating pharmaceutical services) where the term is used.

Facility

The Department is amending this definition by referring to the definition of "long-term care nursing facility" in section 802.1 of the act (35 P. S. § 448.802a). The previous definition was identical to the definition of "long-term care nursing facility" in the act. The Department of Aging had suggested that the Department define "facility" as an entity that includes housing and comprehensive medical services. However, the definition of "facility" in the regulations must be the same as a long-term care nursing facility, which is the licensed entity that the act authorizes the Department to regulate.

*Interdisciplinary team*

A definition is now included for the term "interdisciplinary team." This definition has been taken from the Federal regulation at 42 CFR 483.20(d)(2)(ii), which lists the professionals who must take part in the preparation of residents' care plans. IRRC and the PANPHA feel that the words "the participation of" should be deleted from the proposed definition to ensure that the resident or family member will be included.

PANPHA expressed a concern that the definition did not fully relay the fact that the resident and the resident's family are an integral part of the team. The Department of Aging pointed out that the resident may not have family, and recommended that the team should include the responsible person. The Department has revised the definition to address both concerns.

The Department concludes that the Federal requirement adequately protects the resident's interests. The Federal language requires the facility to use its best efforts to include the resident or the resident's representative, but allows for some flexibility for those limited situations where it is not possible to do so, such as where a resident is incapacitated and has no representative or family members to participate.

*Locked restraint*

PACAH and the Philadelphia Geriatric Center recommended deleting the definition of "locked restraint" as it

is no longer used. The Department does not agree that the definition should be deleted at this time.

*Long term care nursing facility*

The definition of a "long-term care nursing facility" has been deleted as it is referred to in the revised definition of "facility."

*Mantoux tuberculin skin test*

The Department has deleted this definition as it is now referred to as an "intradermal skin test" and defined in § 201.22(d) (relating to notification of change in patient status).

*Medical record practitioner*

The Department agrees with comments from IRRC, an accredited record technician and the Pennsylvania Health Information Management Association (PHIMA) that the definition relates to the clinical record keeping requirements in § 211.5 (relating to clinical records) and should specify criteria for personnel in charge of these records. The Department recognizes that the issues surrounding medical record keeping have become more complex, has reconsidered its proposal to delete the definition, and has updated the definition to reflect the present requirements of the American Health Information Management Association (AHIMA).

*Nurse aide*

After considering comments by the Department of Public Welfare, the Pennsylvania Nurses Association (PNA) and IRRC, the Department has amended the definition of "nurse aide" to reflect the Federal language and to require that the person be in good standing on the Pennsylvania nurse aide registry. This will require all facilities, including those that do not participate in the Medicare or MA Programs, to hire nurse aides who have received or are in the process of receiving required training and evaluation.

*Resident*

The term "resident" has been added to the definitions and replaces the term "patient" throughout the regulations. This change has been made in order to be consistent with Federal terminology and to reflect the fact that for the most part individuals in long-term care nursing facilities are residing there.

*Restraint*

The definition of "restraint" has been revised in accordance with the guidelines to the Federal certification regulations and now specifically includes chemical restraints. Further, the definition now includes devices which are adjacent to a resident in addition to those which are applied to a resident and, depending on the situation, could include side rails. This is also consistent with the Federal view of what constitutes a restraint.

*Serious violation*

The Department has deleted the definition of "serious violation" as it is defined in section 811 of the act (35 P. S. § 448.811 (1)).

*Skilled or intermediate nursing care*

The Department is deleting the definition of "intermediate care" and including a new definition of "skilled or intermediate care" which is in keeping with the elimination of the distinction between these two levels of care since the implementation of the case-mix reimbursement system. The new definition reflects a range of care, rather than two separate levels of care, which may be provided in a nursing facility.

The PANPHA and the Department of Aging support the integration of the levels of care, however, the PANPHA and Presbyterian Senior Care suggested that the Department delete the portion of the definition that states the care is that which is provided to "an individual not in need of hospitalization" and "above the level of room and board." The Department did not delete these provisions as it believes it is necessary to identify the appropriate level of care to be provided in the facility and to distinguish this level of care from personal care or acute care provided in hospitals.

The PHCA would like to see the term "intermediate" deleted and the Department of Public Welfare suggested that the Department just define "nursing care" instead of "skilled or intermediate care." The Department is bound by the definition of "long-term care nursing facility" in the act which specifically references "skilled or intermediate care."

IRRC expressed concerns that, due to differing usage in other regulations pertaining to provision and payment of services in long-term care facilities, the use of the word "daily" may cause confusion. The Department intends this word to be interpreted according to common usage, that is, these services must be available 7 days each week to the residents of the facility.

*Social worker*

Although one comment was received that opposed the proposed revised definition, the Department has adopted the Federal definition of a qualified social worker, as proposed, which requires a bachelor's degree in a human service field and one year of experience. The comment objected to the former requirement that the individual be a graduate of a school of social work accredited by the Council on Social Work or have 1 year of experience in a health setting. The revised definition is more strict in that it requires a degree as well as experience in a health care setting.

*Therapeutic recreation specialists*

The Department deleted the definition of "therapeutic recreation specialists," as it has adopted the Federal regulation in 42 CFR 483.15(f) (relating to quality of life). The Federal provision provides that resident activities must be directed by a qualified therapeutic recreation specialist and includes the requirements for these individuals.

*Section 201.12. Application for license.*

Former subsection (b), requiring the issuance of a Certificate of Need (CON) as a condition of licensure, has been deleted.

*Section 201.13. Issuance of license.*

This section sets forth licensure fees and has been revised to reflect the statutory increase in fees which have been in effect since 1992, following amendments to the act.

*Section 201.14. Responsibility of licensee.*

The Department received a number of comments to the proposed revisions of this section. It has been revised in the final version so as not to duplicate provisions in the publication in June of 1998 of Chapter 51, which includes general provisions applicable to all health care facilities, including required incident reporting. The Department has revised this section to cover those situations that are

not completely addressed in § 51.3 (relating to notification). Subsection (e) will now require the reporting of serious incidents within 24 hours. Subsection (d) will add a requirement that facilities report deaths occurring in the facility or following a hospital admission due to sepsis.

Incidents such as temporary disruptions of services, deaths due to injuries, accidents or suicide, elopements and complaints of resident abuse, which are covered in § 51.3 have been deleted from this section.

The PHCA commented that the phrase "following a hospital admission" should be deleted from subsection (d)(1), as the facility should not be responsible for reporting deaths that occur in the hospital. The PANPHA expressed some uncertainty as to whether the facility must track a resident who is admitted to a hospital for a lengthy stay. As all health care facilities are required to report deaths due to malnutrition, dehydration or sepsis under § 51.3, if the resident is transferred to the hospital and subsequently dies of one of these causes, the hospital will be responsible for reporting the death. Therefore, the Department has deleted the provision in the proposed regulations which would have required nursing facilities to report these deaths following a hospital admission.

The PACAH also questioned why the Department is requiring reporting on transfers as well as subsequent admissions to hospitals as a result of accidents and injuries. The Department believes it is important to be notified of accidents and injuries that require a resident to be sent to the hospital, even if there is no need for subsequent admission.

Several commentators, including the PANPHA and PHCA, questioned why the proposed regulations require facilities to report hospitalizations due to sepsis. The proposal would also require that deaths occurring in the facility or following a hospital admission due to malnutrition or dehydration be reported by the facility. The Department has reevaluated this requirement and deleted the subsection in light of the regulation at § 51.3(g), which requires all licensed health care facilities to report resident or patient deaths due to malnutrition, dehydration or sepsis. Therefore, a death due to malnutrition, dehydration or sepsis would be reported by the facility where the resident or patient expired.

The PACAH felt that the current 24 hour time frame for reporting in subsection (e) is insufficient time to allow the facility to fully investigate the incident being reported. The PHCA suggested the time frame be within 24 hours of the first working day after the incident. The Department considers the 24 hour time frame to be important. An investigation does not have to be completed within the 24 hour period for initial reporting of an incident. Facilities may report emergencies by the Department's hot line after hours or on weekends and holidays.

*Section 201.15. Restrictions on license.*

The Department has deleted subsection (c), as the language defining a "serious violation" is part of the act. Former subsection (d), which is now subsection (c), has been amended to reflect that an appeal from an order of the Department is to the Health Policy Board. This is consistent with an amendment to The Administrative Code of 1929 (71 P. S. § 2102(n)), in 1996, which transferred the duties of the former State Health Facilities Hearing Board to the Health Policy Board.

*Section 201.16. Change in ownership, structure or name.*

The requirements in this section have been addressed in § 51.4 (relating to change in ownership; change in management). Therefore, this section is being repealed.

*Section 201.17. Location.*

The PANPHA and PACAH questioned whether the Department was proposing to delete this section. The Department did not address this section in the proposed rulemaking and has not deleted or amended this section.

*Section 201.18. Management.*

Former subsection (j) is now subsection (h). It requires facilities which accept responsibility for residents' financial affairs to provide residents with access to their money within 3 bank business days from the date of request. The regulation had provided for 7 days.

IRRC and St. Mary's Home of Erie commented that subsection (e)(7), which requires a strike plan, should only be applicable to unionized facilities. As the Department has applied this requirement to unionized facilities only, it agrees and has clarified this in the subsection.

*Section 201.19. Personnel policies and procedures.*

This section has been revised to delete all subsections except for former subsection (b). The subsections which have been deleted are either covered by the Federal regulations which have been adopted or are included in other sections of these regulations.

The University of Pennsylvania Health System's Institute on Aging raised a question with regard to former subsection (i), which required employes to have a chest X-ray within the previous 60 days if the intradermal tuberculin skin test was positive. The question was whether a chest X-ray taken more than 60 days prior to the skin test would be satisfactory. Revised § 201.22 (relating to prevention, control and surveillance of tuberculosis (TB)) addresses tuberculosis protocols and provides that an employe or resident whose skin test is positive shall be referred for further diagnostic testing and treatment in accordance with current standards of practice.

*Section 201.20. Staff development.*

Subsection (c) has been revised to require annual in-service training on resident rights.

*Section 201.21. Use of outside resources.*

In response to a comment by the PANPHA, the Department has revised subsection (a) to require facilities to ensure that personnel and services provided by outside resources meet all necessary licensure and certification requirements.

*Section 201.22. Prevention, control and surveillance of tuberculosis (TB).*

This section addresses the testing of residents and personnel for tuberculosis. The Department has revised this section, including its title.

The proposed criteria were based on National standards, including CDC protocols. The Pennsylvania Medical Society (PMS) expressed its approval of the Department's inclusion of National guidelines and standards, including those of the CDC.

A fellow with the University of Pennsylvania Health System's Institute on Aging suggested that the regulations address the situation where a resident or a responsible person refuses the required testing. Another commentator suggested that terminally ill residents not be

tested. The Department believes that these situations will need to be reviewed on a case by case basis. If necessary, exceptions can be granted in individual situations.

The Hospital and Health System Association of Pennsylvania (HAP) commented that SNFs in hospitals should be granted automatic exceptions to subsection (c)'s requirement of baseline TB testing on residents. The Department does not believe it would be appropriate to grant a blanket exception to hospital-based SNFs. Instead, it believes that any exceptions should be requested on a case by case basis. The regulations do not require that the 2-step test be complete before a resident is admitted. However, the facility must obtain a base line TB status on each resident.

The PANPHA questioned the requirement in proposed subsection (h) which required volunteers having 10 or more hours per week of contact with residents to be tested along with employes having the same contact. The Department recognized the difficulty facilities would face if forced to test volunteers and, therefore, has deleted the reference to volunteers.

Several commentators, including the University of Pennsylvania Health System's Institute of Aging, the PACAH and PANPHA, asked whether the TB testing of personnel must be preemployment. Another commentator questioned whether an employe who has a new positive reaction to the skin test may continue to work in the facility pending the results of a chest X-ray. Subsections (j) and (m) provide that testing and results are to be preemployment. Therefore, an employe having a new positive reaction would not be permitted to have contact with residents until the facility had chest X-ray results indicating the employe did not have TB. Subsection (j) has been revised to clarify that the 2-step intradermal skin test must be administered to employes prior to employment.

Two commentators felt the section was unclear as to what was meant by "previous positive reaction" in subsection (l). The Department is referring to those residents or employes who have prior history of a positive skin reaction but have no diagnosis of active TB.

The PANPHA and the United Church of Christ Homes suggested that the criteria in subsection (n) is too strict and that a facility should be permitted to admit a resident with infectious tuberculosis if the facility has a negative pressure room and is otherwise able to handle the resident's condition. The Department recognizes that subsection (n) is strict, but concludes that the criteria for admission of residents with diagnoses of TB are necessary to adequately safeguard other residents.

*Section 201.24. Admission policy.*

The Department proposed to delete this section in its entirety, but in light of comments received, including comments from the Department of Aging, the Pennsylvania Health Law Project and Community Legal Services, has decided to keep subsections (a)—(d). The commentators felt that it was important to state that a resident does not have to name a responsible person if the resident chooses not to do so. In response to a comment from the Department of Aging, the provision in subsection (a) which allowed facilities to name a resident's responsible person as a third-party financial guarantor if the agreement was in writing, has now been deleted to reflect the Federal regulations which prohibit third-party guarantees.

The Pennsylvania Health Law Project and Community Legal Services suggested it was important to keep subsection (b) to prohibit an express waiver of liability or of certain resident rights in an admission agreement.

Subsection (e) has been deleted as it is dealt with more specifically in § 201.22(n) (relating to prevention, control and surveillance of tuberculosis (TB)).

*Section 201.25. Discharge policy.*

It was proposed that this section was to be deleted in its entirety. However, the Department agrees with a comment by Community Legal Services that subsection (a) should be retained as the Federal regulation at 42 CFR 483.12(a)(7) (relating to admission, transfer and discharge) only requires "sufficient preparation and orientation" prior to discharge and does not specifically address the need for coordinated discharge planning. It is important that a resident have a single coordinated discharge plan rather than separate plans from various disciplines.

Additional language has been added to § 201.29(e) and (f) (relating to resident rights) regarding the facility's responsibilities with regard to transfer and discharge of residents. The new language clarifies that 30 days advance notice must be given prior to discharge and that the facility is responsible for assuring that the resident is appropriately placed.

*Section 201.26. Power of attorney.*

The PANPHA had requested that the Department expand this section to address situations where a resident has no power of attorney for health care and is unable to make his wishes known. The Department is unable to regulate in this area. Facilities are bound by current State law surrounding power of attorney, advance directives and guardianship.

Although the Department recognizes the difficulties facilities face in these situations, guidance in this area must come from the legislature or the courts. The Department notes that facilities which participate in MA are to provide the summary of State law concerning advance directives to residents upon admission. All facilities should offer residents the opportunity to draft a living will if they are competent and wish to do so.

*Section 201.27. Advertisement of special services.*

In response to a comment from the Pennsylvania Association of Rehabilitation Facilities (PARF), the Department decided to retain this section. It provides that facilities may not advertise special services such as rehabilitation or physical therapy unless the service is provided by specifically trained personnel.

*Section 201.28. Nondiscriminatory policy.*

This section has been repealed. The subject matter is now addressed in §§ 51.11—51.12 (relating to civil rights compliance and nondiscriminatory policy) in the general administrative chapter which applies to all health care facilities.

*Section 201.29. Resident rights.*

The Department proposed to delete subsections (a)—(c), as the Federal regulations address resident rights. These subsections provided that facilities are to have written policies regarding the rights and responsibilities of residents and are to make them available to residents, staff and consumer groups.

In response to comments from Community Legal Services and the PANPHA, the Department has decided not to delete subsection (a) and to revise subsection (b) by adding a provision which requires that resident rights

policies be available to residents and members of the public. Subsection (c) is also retained.

In light of a comment from the PACAH, the Department has clarified the language in subsection (e) to ensure that information regarding available services and charges which are covered by the facility's per diem rate is first provided to the resident, if competent, and to the resident's responsible person if the resident is not competent.

Former subsection (h) is now subsection (f) and includes subject matter previously dealt with in former § 201.25 (b) (relating to discharge policy) which provided for reasonable advance notice of 30 days prior to a transfer or discharge of the resident. HAP had suggested that the Department include a provision automatically exempting hospital-based SNFs from the 30-day notice provision, as many residents are not in these units that long. The Department does not see the need to include a specific exception in the regulation, as there is a provision that the transfer or discharge may be implemented in less than 30 days if the plans are suitable to the resident.

In response to a comment from the Department of Aging, language has been added to subsection (f) which requires the transferring facility to inform the resident of its bed-hold policy prior to transfer.

The PACAH commented that amended subsections (f) and (g), which provide that the facility is responsible for a safe and orderly transfer, are covered by the Federal regulations in 42 CFR 483.12 and should be deleted. Although 42 CFR 483.12 does address the transfer and discharge issue, the Department believes that the language in amended subsections (f) and (g), as revised, is more specific than the Federal language in that it provides that the transfer or discharge without 30-days advance notice must be acceptable to the resident. Further, subsection (g) specifically states that the receiving facility must be capable of meeting the resident's needs. In response to a suggestion from the Department of Aging, the Department added language to subsection (g), requiring transferring or discharging facilities to inform the resident as to whether the receiving facility participates in the Medicare or MA programs, or both.

As proposed, subsection (f) had stated reasonable advance notice was to be interpreted as 30 days "unless appropriate plans could be implemented." The Department agreed with the assessment of St. Mary's Home of Erie that this was unclear. Therefore, it has clarified the phrase by adding the word "sooner" after "implemented." Also, the Department, in response to comments by the PANPHA, has further clarified the provision by specifying that transfer or discharge plans executed with less than 30 days notice, must be acceptable to the resident. The subsection was further clarified by adding language requiring that suitable clinical records, in addition to a list of medications and treatments, accompany the resident being transferred.

The Department added subject matter to subsection (g) which had been addressed in former § 201.25(g), which provided that it is not necessary to transfer a resident between or within a facility if in the opinion of the attending physician such a transfer would be harmful to the resident.

The Department had proposed to delete subsection (i), but has accepted the recommendation of Community Legal Services that it be retained. The PACAH had supported the deletion of the subsection, as Federal regulations address the provision of advocacy information to residents, but encouraged the retention of language giving hot line numbers and requiring that this information be provided to residents. Subsection (h) contains information that is specific to Pennsylvania and therefore appropriate to retain.

The Department deleted former subsections (j)—(n), as the same subject matter is addressed by the Federal regulations. Community Legal Services requested that former subsection (j) be retained. However, the Department feels that this subsection is fully addressed in 42 CFR 483.10(a)(2).

The Pennsylvania Health Law Project and Community Legal Services requested that the Department retain former subsection (l), which provided that where a facility is responsible for a resident's funds, the facility must maintain written policies that assure the resident receives a quarterly accounting and prohibit the facility from commingling the resident's funds with its own. The Federal regulation in 42 CFR 483.10(c)(4)(i) and (ii), prohibits commingling of resident and facility funds and requires that the resident be provided with financial statements each quarter and upon request. Although the Federal regulation does not specifically require written policies, it does require the facility to have a system to assure full, complete and separate accounting. The Department would cite a facility whose system is inadequate. Therefore, the Department believes that the Federal regulation fully addresses the provisions of former subsection (l).

In response to a comment from Community Legal Services, the Department is retaining former subsection (o), which provides that the resident is to be treated with consideration, respect and in full recognition of dignity. Although the Federal regulations are similar, subsection (o), now subsection (j), is broader. The commentator further complimented the Department on its interpretive guidelines to this subsection.

Former subsections (p)—(s) and (u), which addressed the resident's right to associate freely with members of the resident's family and the community, have been deleted as they are covered by Federal regulations which have been adopted. Although former subsection (p), which prohibited a resident from performing services for the facility, is not specifically dealt with in the Federal regulations, subsection (j) of the revised licensure regulations, which requires a resident to be treated with dignity, would prohibit this.

In response to comments from the Pennsylvania Health Law Project and Community Legal Services, the Department is retaining former subsection (t), now subsection (k), which permits residents to retain personal clothing and possessions and mandates that facilities make provisions for the proper handling of these items.

The Department proposed to delete former subsection (v), which listed rights which devolve to a resident's responsible person in situations where the resident is adjudicated incapacitated, found by their attending physician to be incapable of understanding their rights, or unable to communicate.

Comments were received from the Pennsylvania Medical Directors Association, the PMS, the Pennsylvania Health Law Project and Community Legal Services, urging the Department to retain this section, as they felt the Department should address surrogate decision making through regulation.

Although the Department recognizes the need for providers to have guidance on treatment issues for incapaci-

tated residents, it has reservations as to whether Pennsylvania law actually permits a responsible person to make certain decisions concerning their treatment in situations where the resident has not been adjudicated incapacitated. Even in situations where there is a durable power of attorney for health care, it is not clear whether a responsible person is authorized under Pennsylvania law to exercise certain residents' rights such as the right to refuse or discontinue life sustaining treatment. A responsible party would need a valid advance directive specifically authorizing such a refusal or appointing that individual as the surrogate decision maker.

The Department has addressed these competing concerns by redesignating former subsection (v) as subsection (l) and revising it to allow for a resident's right to devolve to a responsible person where the resident has been adjudicated incapacitated or "as Pennsylvania law otherwise authorizes." This permits decisions on a case-by-case basis and allows for changes in the law of surrogate decision-making. Facilities may wish to obtain legal guidance in developing procedures and protocols in this area.

In response to comments from Community Legal Services, the Department is retaining former subsections (x) and (y), now subsections (n) and (o). These subsections require resident rights to be posted and fully explained to residents who cannot read and/or who do not understand English. Further, they prohibit experimental treatment or research without Department approval and full disclosure to residents. The Pennsylvania Long-Term Care Pharmacist's Coalition disagreed with the requirement that facilities must obtain Department approval prior to implementing experimental research such as clinical drug trials using residents. Rather they felt these procedures should instead be run past an institutional review board. The Department's requirement that experimental research be approved is simply to ensure that the resident is fully informed of the risks, if any. The facility still needs to obtain any further requisite approvals regarding clinical validity of the treatment or trials from the appropriate regulatory agencies such as the FDA.

*Section 201.30. Access requirements.*

The Department had proposed to delete this section with the exception of former subsection (f), now subsection (b), which provides that a person entering a facility shall identify himself and receive permission from the resident to enter the resident's room. The PACAH suggested that the deletion of former subsection (e), now subsection (a), which permits facilities to limit access, would tie the hands of facilities charged with the responsibility for the resident. The Department is retaining this subsection, but has adopted the PACAH's suggestion that access be limited only in those situations where the interdisciplinary care team has determined that access would be detrimental to the resident's health. Any complaints from residents, family or friends regarding access restrictions will be swiftly and thoroughly reviewed by the Department.

The Pennsylvania Health Law Project urged the Department to prohibit facility personnel from questioning attorneys as to the reason for visiting the resident. The Department incorporated a provision to this effect and expanded the prohibition to cover the Department of Aging ombudsman as well as any representative of the Department who may wish to speak directly with a resident.

Former subsection (h) has been deleted as its subject matter is now addressed in § 201.29 (relating to resident rights).

*Section 201.31. Transfer agreement.*

The Department proposed to delete subsection (a). The Department has decided that the subsection is necessary, but has revised subsection (b) to state that a transfer agreement must provide for the interchange of necessary medical information as well as the transfer of residents' personal effects.

Former subsection (c), which dealt with facilities not having a transfer agreement with a hospital, has been deleted.

*Section 201.32. Room placements.*

This section has been repealed. The Department believes it is obvious that a married couple may share a room if they so desire and that such a directive by way of a regulation is not necessary. Furthermore, the Federal regulations in 42 CFR § 483.10(m), which is part of the section on resident rights being adopted by the Department, provides for this right.

*Chapter 203. Application of Life Safety Code for Long-Term Care Nursing Facilities.*

The Department has revised § 203.1 (relating to application of the *Life Safety Code*) to state that facilities are to comply with the applicable edition of the Life Safety Code that has been adopted by the Department.

Former § 203.2 (relating to restrictions) required long-term care facilities to comply with certain Life Safety Code standards. As all long-term care facilities are currently required to meet Life Safety Code construction and sprinkler requirements, this section is duplicative. The Department has repealed this section.

*Chapter 205. Physical Plant and Equipment Standards for Long-Term Care Nursing Facilities.*

*Buildings and Grounds*

*Section 205.3 Building approval.*

This section has been deleted. Its requirements that no new constructions or alterations may be occupied until the Department has authorized occupancy, appear at § 51.5 (relating to building occupancy).

*Section 205.4. Building plans.*

This section sets forth the requirements for both preliminary and final architectural plan approval. Only one set of plans will now be required. The Department has incorporated the preliminary plan criteria in former subsection (f), in subsection (e), former subsection (h) which addresses the final plan submission.

Although the PANPHA supports the Department's effort to streamline the physical plant section and to permit providers more flexibility, it suggested that the Department continue to require a preliminary and final plan approval process, as the two-step process was helpful to providers in that it identified many necessary changes needed in the architectural, mechanical and electrical plans. The Department will continue to work with providers and will review plans prior to final submission if requested to do so. The final submission of plans may also be revised if the review finds that there are necessary changes to be made.

The Department adopted a recommendation from PANPHA that the reference to preliminary plans be deleted from former subsection (c), now subsection (b).

*Section 205.5. Number of building plans to be prepared.*

This section, which required preliminary plans to be filed in duplicate, has been repealed.

*Section 205.7. Basement or cellar.*

The Department has deleted subsection (a).

*Section 205.8. Ceiling heights.*

Subsections (a) and (b) have been deleted, permitting ceiling heights except in boiler rooms to be 7 feet, 6 inches.

*Section 205.9. Corridors.*

The Department has deleted former subsections (a) and (b) and added a prohibition that corridors may not be used for storage. One commentator asked the Department to clarify the section to permit the temporary storage of equipment while serving residents. The Department has decided not to do so as it does not want to raise issues of what is temporary, or permit the temporary storage of items such as geri-chairs and IV equipment.

*Section 205.14. Locks.*

Although the Department did not propose any substantive changes to this section, the PANPHA requested that protocols for special locking arrangements (SLAs) be included in the regulations. The Department has decided not to issue standard protocols at this time. Instead, it feels that it is important to look at each individual request for an SLA on a case-by-case basis to ensure residents subject to these exceptions are provided with sufficient therapeutic activities and that staffing will not decrease as a result of an exception being issued. However, the Department is accepting IRRC's recommendation that the issue be studied and, if necessary, addressed in future rulemaking.

*Section 205.20. Resident bedrooms.*

This section is amended to require only a flat amount of square footage for single and multibed rooms and to delete additional minimum space requirements within the square footage requirement. For example, a single-bed bedroom must still have a minimum room area clearance of 100 feet, but requirements that there be a minimum of 3 feet between the bed and the adjacent wall and 4 feet between the foot of the bed and the opposing wall or furniture have been deleted.

The Department had received reports that these requirements sometimes mandated bed placements which were contrary to a resident's preference. It wants to provide facilities with the flexibility to arrange rooms in various ways. The PANPHA commended the Department's decision to delete the specific spacial requirements within the minimum square footage.

*Section 205.21. Special care room.*

The PANPHA pointed out that the special care room should be required to have negative pressure and that this should be reflected in § 205.66 (relating to special ventilation requirements for new construction) which sets forth special ventilation requirements. This section has been amended to require ventilation as specified in § 205.66.

*Section 205.24. Dining room.*

The Department has deleted former sections (a) and (b) which addressed the space requirements when a facility combined a dining room and a recreation area. Former subsection (c) is now subsection (a). A new subsection (b) is added which requires tables and space to accommodate wheelchairs. St. Mary's Home of Erie inquired as to whether the Department will make exceptions for facilities which do not provide tables and space to accommodate wheelchairs. As with all requests for exceptions, the Department will review requests individually under § 51.33 (pertaining to requests for exceptions) which requires the publication of the request as well as the determination in the *Pennsylvania Bulletin*.

The PACAH commented that the requirement that adaptive devices be provided to facilitate the eating of meals was not included in this section, but supported its deletion as it is covered by Federal requirements. This language appeared instead in § 211.6(h) (relating to dietary services) and has been deleted.

*Section 205.25. Kitchen.*

The PACAH suggested that the entire section be deleted as it felt it was overly prescriptive. Most of the requirements for a kitchen have been deleted with the exception of subsection (a), which requires that there be a kitchen, and former subsection (d), now subsection (b), which requires a service pantry on each unit.

*Section 205.27. Lounge and recreation rooms.*

The Department deleted former subsections (b) and (c) and retained the text of subsection (a) with a minor amendment. A comment was received from a nursing home administrator regarding former subsection (a), that lounges should not be required on each floor. The requirement is for lounges on each floor rather than each unit. The Department believes it is important that residents not have to go to another floor, to visit the lounge area, which could require the negotiation of stairs.

*Section 205.31. Storage.*

The Department has retained the text of subsection (a). This provision requires that for each bed there be a minimum of 10 square feet of storage space provided for items, including residents' possessions. A couple comments were received suggesting that former subsections (c) and (d), pertaining to storage of residents belongings and indoor recreation equipment, be deleted. These subsections have been deleted as had been proposed.

*Section 205.33. Utility room.*

The Department has added a new subsection (b), which requires separate bedpan flushers to be provided in soiled workrooms unless a facility has them in residents' bathrooms. Also, a new subsection (c) has been added which requires hand-washing facilities in soiled and clean utility rooms. Former subsections (b) and (c) were deleted.

*Section 205.34. Treatment room or examining room.*

This section has been deleted.

*Section 205.35. Telephone.*

This section has been deleted. The Federal regulations which are being adopted require that residents have access to a telephone.

*Sections 205.36. Bathing facilities, 205.37. Equipment for bathrooms, 205.38. Toilet facilities, 205.39. Toilet room equipment, and 205.40. Lavatory facilities.*

These sections address bathrooms, toilet rooms and lavatories. The Department has deleted requirements as to the size of tubs and shower stalls while retaining the requirement of a minimum clearance around bathtubs in § 205.36(h).

Subsections (c) and (d) were originally proposed to be deleted in § 205.37. The Department received a recommendation from an administrator and a facility that subsection (d)'s requirement of a dressing area next to the shower be deleted. However, in light of past incidents involving resident injury while bathing, the Department

has determined that the entire section should remain and that additional language should be added to subsection (c) to require appropriate supervision of and assistance for residents being bathed. The Department believes subsection (d)'s requirement of a dressing area next to the shower will help to prevent resident falls.

A new subsection (e), which requires that bath water temperature be tested before a resident is bathed, has also been added to this section. One commentator suggested requiring comfortable air temperature as well, but the Department considers this matter to be adequately covered in Federal regulations which require a comfortable environment.

In § 205.38, the Department proposed to delete subsections (b)—(e) while keeping subsection (a) and subsection (f), now designated as subsection (e), which requires a minimum ratio of 1 toilet per 4 residents. After reviewing comments received, the Department decided to keep subsection (b), which requires no less than 3 1/2 feet of space from the front of the toilet to the wall, and the first sentence of subsection (c), which requires at least one toilet on each floor to accommodate residents in wheelchairs. The specific spatial requirements which were previously listed were deleted in response to a question from the PANPHA as to whether or not the dimensions were adequate to accommodate wheelchairs and other assistive devices. The Department also decided to keep former subsection (g), now designated as subsection (f), which requires separate toilets and lavatories for use by visitors.

*Sections 205.61. Heating requirements for existing and new construction, 205.62. Special heating requirements for new construction, 205.63. Plumbing and piping systems required for existing and new construction, and 205.64. Special plumbing and piping systems for new construction.*

The Department has deleted several subsections from these sections which address heating requirements and plumbing and piping systems, since these are for the most part covered in the NFPA 101 Life Safety Code which is already incorporated by reference in § 203.1 (relating to application of the Life Safety Code).

Although § 205.61(a) was proposed to be deleted, the Department has rethought this proposal. It has determined that it should retain a reference to local and State building codes and continue to require that the most stringent apply.

*Section 205.66. Special ventilation requirements for new construction.*

This section sets forth special ventilation requirements for new construction. Amendments have been made to the chart contained in subsection (a). Criteria for the special care room have been added in response to a comment from the PANPHA. The provisions for exam and treatment rooms have been deleted to reflect that former § 205.34, pertaining to exam and treatment rooms, has been deleted.

*Section 205.67. Electric requirements for existing and new construction.*

In response to a comment from the PANPHA, the Department has deleted the reference to lighting which is satisfactory for sewing as well as the reference to 200 footcandles. It has also revised the section to simply require lighting which is satisfactory for resident activities.

*Sections 205.71. Bed and furnishings and 205.72. Furniture.*

Most of the provisions in these two sections have been deleted. However, the Department is retaining the requirement in § 205.71, that a bed be equipped with an appropriately sized mattress, and in § 205.72, that each resident have a bedside drawer or cabinet which can be locked. References to all other types of furniture such as bedside chairs, overbed tables and footstools have been deleted. Much of former § 205.72(j) is retained, however, the former exception to the requirement of a drawer or cabinet in former subsection (j) has been deleted. It is important that every resident have a locked drawer or cabinet in which to store personal possessions.

*Sections 205.73. Sterilization.*

This section, pertaining to sterilization requirements, has been repealed. Sterilization is covered under the general infection control provisions in the Federal regulations at 42 CFR 483.65.

*Section 205.74. Linen.*

This section, which requires a sufficient quantity of linen, was proposed to be deleted in its entirety, as the Federal regulations require that facilities have bedding which is appropriate to the climate. The Department agrees with a comment from the PANPHA that the Federal requirement alone is not sufficient. Therefore, the text of former subsection (a), requiring sufficient linen, has been retained, although the specific requirement of three daily changes of linen per resident has been deleted.

*Section 205.75. Supplies.*

The PACAH suggested that the Department delete this section arguing that it is repetitive of Federal and State regulations. The Department is retaining the section as there is no direct Federal regulation generally requiring adequate supplies.

*Chapter 207. Housekeeping and Maintenance Standards for Long-Term Care Nursing Facilities*

*Sections 207.1. Environmental safety and 207.3. Housekeeping.*

These sections address environmental safety, housekeeping and maintenance. The Department is repealing them in light of the general requirement in § 207.2(a) (relating to administrator's responsibility) that the administrator be responsible for the satisfactory housekeeping and maintenance of the buildings and grounds.

*Section 207.2. Administrator's responsibility.*

The provision in subsection (b) which required a full-time employe to be responsible for housekeeping and maintenance and for the training of personnel has been deleted. The Department has also deleted former subsection (c) which specifically stated that the administrator is responsible for ensuring contract services meet the requirements of the chapter. It was concluded that this did not have to be specifically stated, as the administrator is responsible for ensuring that the licensure requirements are met whether they are performed by employes or contracted out.

*Section 207.4. Ice containers and storage.*

Former subsections (b)—(d) have been deleted. The Department retained the general provision in former subsection (a), which requires the sanitary handling of the ice storage container.

*Section 207.5. Maintenance of equipment and building.*

This section has been repealed. Its provisions are adequately addressed in § 207.2(a) (relating to administrator's responsibility), which provides that the administrator is responsible for the satisfactory housekeeping and maintenance of the facility.

*Chapter 209. Fire Protection and Safety Programs for Long-Term Care Nursing Facilities*

*Section 209.1. Fire department service.*

In response to a comment from the Department of Aging, the reference to the fire department in this section has been changed to emergency services to reflect the fact that most areas are covered by an emergency notification system.

*Section 209.2. Hazardous areas.*

In response to a comment by the PACAH, this former section, which addressed requirements for pipes and radiators in residents' rooms, has been repealed, as these matters are addressed in § 205.61 (relating to heating requirements for existing and new construction).

*Section 209.3. Smoking.*

The Department proposed to retain only subsection (a), which provides that the facility must have smoking policies, and subsection (b), which requires the facility to take safeguards against smoking related fire hazards. Subsections (c)—(g), which mandate certain smoking precautions, were to appear as guidelines to the regulation.

The PACAH commented that it agreed with the retention of subsection (b), but did not agree with the proposed deletion of subsections (c)—(f). In response to a smoking related incident, as well as the PACAH's comment, the Department concluded that it was important to retain the entire section and to reword subsection (c) to require adequate supervision for smoking residents who require it. Although subsections (e)—(g) are addressed in the Life Safety Code, the Department determined that it was important to also specifically retain them in the licensure regulations.

Both the PACAH and the University of Pennsylvania Medical Center's Institute on Aging, commented on this section. The PACAH urged the Department to address in subsection (a) the rights of smoking residents as well as nonsmoking residents, and to require that the policies be reviewed upon admission. The rights of smoking residents are already addressed in this section. The Department will review any complaints by smoking residents on a case by case basis.

The Institute on Aging and PACAH stated that they would like the Department to address the protection of employes by adopting regulations banning smoking entirely in facilities. The Department believes that this is an issue to be negotiated between the employes and each individual facility, and that a specific disposition should not be dictated by regulation.

*Sections 209.4. Fire extinguishers, 209.5. Emergency lighting system and 209.6. Fire alarm.*

These sections are being repealed, as the matters they address are already addressed in the NFPA 101 Life Safety Code. The Department has moved former § 209.6(b), requiring personnel to be instructed in the use of fire extinguishers, to a new § 209.7(c) (relating to disaster preparedness).

*Section 209.7. Disaster preparedness.*

This section has been revised by deleting former subsection (a) and incorporating its requirement that the facility have a comprehensive written disaster plan into former subsection (b), now subsection (a). Also, the requirement that had been included in § 209.6 (relating to fire alarm), requiring all employes to be instructed in the use of fire extinguishers, is added in subsection (c). The PANPHA asked whether all employes must be instructed in the use of the fire extinguishers. Recognizing the potential for disaster which a fire in a long-term care nursing facility could have, the Department feels it is necessary that all employes be instructed in the use of the fire extinguishers and has clarified § 209.7(c) accordingly.

There are a limited number of types of extinguishers which facilities would use and local fire companies and departments are often willing to assist in this type of instruction.

*Chapter 211. Program Standards for Long-Term Care Nursing Facilities*

*Section 211.1. Reportable diseases.*

This section which was titled "Infection control," has been amended and is now titled "Reportable diseases." The list of reportable has been updated. A new subsection (c) has been added to require facilities to report cases of resistant bacterial infections such as Methicillin Resistant Staphyloccus Aureus (MRSA), Vancomycin-Resistant Enterococci (VRE) and Vancomycin-Resistant Staphylococcus Epidermidis (VRSE) to the local field office for the Division of Nursing Care Facilities.

Cedarbrook and Lehigh County Home asked whether the Department was requiring the reporting of individual cases of MRSA or only nosocomial outbreaks. HAP, PHCA, PACAH and St. Mary's Home of Erie felt that reporting individual cases was cumbersome and unnecessary, and urged the Department to limit the reporting requirement for MRSA to nosocomial outbreaks. The Department has reconsidered the usefulness of this information reported on an individual basis and has revised the subsection to require reporting of only nosocomial outbreaks of the resistant bacterial infections such as MRSA.

The PANPHA suggested that the Department define "nosocomial outbreak," however, such a determination could vary depending on the size of the facility. The Department instead revised the regulation to require the determination of a nosocomial outbreak for reporting purposes to be made by the facility's medical director.

*Section 211.2. Physician services.*

The Department had proposed to amend this section by retaining subsection (e), which states that the attending physician is responsible for the medical evaluation of a resident and for prescribing appropriate care. The Department had also proposed to retain former subsection (l)(2) and (4). These provisions provided that a medical director's duties include review of incidents and accidents which occur in the facility, and the development of policies delineating physician responsibilities. As proposed, the remainder of the paragraphs of former subsection (l) were deleted in light of the adoption of the Federal regulation on physician services and responsibilities of the medical director at 42 CFR 483.40 and 483.75(i) (relating to physician services; and administration).

Good Shepherd suggested the Department retain former subsection (a), which stated that the facility shall have a physician responsible for the needs of the residents. The Department believes this is adequately addressed in the Federal regulations. The commentator, along with Quest Diagnostics and the PANPHA, agreed with the Department's proposed deletion of former subsections (g) and (h), which prescribed various admission and periodic testing of residents and recognized that physicians now have the flexibility to order only those tests they feel are necessary in individual situations.

The PANPHA questioned the requirement of former subsection (e), now subsection (a), that the physician is responsible for the medical evaluation of the resident, as the physician is only part of an interdisciplinary team. The Department is retaining this requirement. Although the team has input into the resident's care plan, the physician has the final responsibility for the resident's medical evaluation.

The Department proposed to delete former subsection (f) in its entirety. This subsection stated that the facility shall have current medical information at admission, and information on the rehabilitation potential with a summary of the prior course of treatment within 48 hours. The University of Pennsylvania Health System's Institute on Aging commented that 48 hours was too short a time for the facility to assess the resident, but felt the Federal requirement of 30 days was too long for the initial physician visit.

The Federal regulation in 42 CFR 483.20 provides that the facility have physician orders at the time of admission and that an assessment be within 14 days of admission. Therefore, the Department deleted the portion of former subsection (f), now subsection (b), which provided for the summary of the rehabilitation potential and prior course of treatment within 48 hours of admission, and is instead requiring that the medical assessment include this information and be conducted no later than 14 days after admission.

Several commentators were confusing the medical assessment required by this subsection with the MDS's functional assessment. One commentator suggested that the Department define "medical assessment"; however, the Department believes that is within the realm of the practice of medicine and therefore a decision to be made by the practitioner.

The University of Pennsylvania Health System's Institute on Aging, the PMS, the Pennsylvania Medical Directors Association (PDMA) and IRRC objected to the proposed deletion of former subsection (k), which states that a facility must have a medical director licensed in this Commonwealth. The Department agrees that the Federal requirement of a medical director in 42 CFR 483.75(i) would not cover the requirement of a Pennsylvania license. Therefore, the subsection has been retained as new subsection (c).

*Section 211.3. Oral and telephone orders.*

Subsection (b) provides that a physician must countersign oral orders for care and treatments within 7 days of receipt of the order. Former § 211.9(h), now subsection (c), provides that physicians countersign oral orders for medications within 48 hours. However, the Department received comments from the PACAH, PHCA and PANPHA that countersignatures for both medications and treatments should be 7 days. St. Mary's Home of Erie noted the problems facilities face with weekend orders. The Department is concerned that there is more of a likelihood that a mistake could be made with oral orders for medications than for treatments, as many medications sound similar and there could be mistakes regarding the dosage. Therefore, the 48 hour time limit is kept for countersignatures to medication orders. In light of the fact that facsimile transmissions are permitted, the Department believes that the 48 hour time limit is not unreasonable and best protects the health and safety of residents.

Both the PNA and IRRC commented that subsection (a) should be amended to reflect that only registered nurses and not licensed nurses may take oral orders. The subsection has been amended to reflect this. IRRC suggested that a section be added providing that licensed practical nurses may accept oral orders only in emergency situations under 49 Pa. Code § 21.145(b) (relating to functions of the LPN). As this is already the scope of practice set forth in the nurse board's regulations, the Department does not feel it is necessary to repeat the regulation here.

In response to a suggestion by the PANPHA, the Department moved former § 211.9(f) (relating to pharmaceutical services) with minor revisions to this section and redesignated it as subsection (c).

Subsections (d) and (e) have been added. They provide that initial written orders and countersignatures may be by facsimile transmission. They also require facilities to have policies and protocols for the taking and transcribing of oral orders. Subsection (d) provides that oral orders shall only be accepted in situations where it is "impractical" for the practitioner to issue a written order. Although the Department recognizes the subjective nature of the term "impractical," subsection (e) requires facilities to identify, through written policies, those types of situations where oral orders would be acceptable. Therefore, the facility will be required to have written policies to follow which the Department will review as part of the survey process.

*Section 211.4. Procedure in event of death.*

Subsections (a)—(c) are deleted. These subsections required a facility to notify a resident's treating physician upon the resident's death and to document the death in the resident's medical record. They also required the physician to complete and sign the death certificate under Article V of the Vital Statistics Law of 1953 (35 P. S. §§ 450.501—450.506). The Department does not believe it is necessary to include these items in licensure regulations, as they reflect standard protocol and existing law.

*Section 211.5. Clinical records.*

The Department has changed the term "medical records" to "clinical records" to be consistent with Federal terminology. It has also deleted former subsections (b), (d)—(g) and (o). Subsection (o) outlined what had to be included in nurses' notes. It is not necessary to include that information in a specific licensure regulation as the information should be included in nurses' notes using standard protocol. The other subsections, which addressed resident requests for copies of records and maintenance of medical record facilities, are adequately covered by Federal regulations in 42 CFR 483.75(l).

The Department proposed to delete the term "medical record practitioner" and amend former subsection (n), now subsection (i), to require that the supervisory responsibility for the medical record service be performed by "personnel competent to carry out the functions of the medical record service." The PACAH agreed with the proposed deletion of the term and related requirements,

as it felt the requirement added an unnecessary expense. However, IRRC, the PHCA, PANPHA and two accredited record technicians (ARTs), urged the Department to expressly set forth basic requirements for qualifications of medical records personnel. The Department has amended subsection (i) to require the medical records service to be assigned to a medical records practitioner and it has included a definition of "medical records practitioner" in § 201.3 (relating to definitions).

Several commentators, including the PANPHA and PHCA, expressed concern that the proposed language prohibited the use of medical records consultants. Therefore, the Department has added specific language to subsection (i) which permits a facility to contract with a medical records practitioner to act as a consultant, but that still requires overall supervisory responsibility of the clinical record service be by a medical records practitioner. The facility which uses a consultant for this purpose must ensure that the consultant devotes a sufficient number of hours to adequately supervise the clinical record service.

*Section 211.6. Dietary services.*

The Department has eliminated former subsections (a), (b), (e)—(j), (l), (n)—(q) and (s). These subsections address adequate staffing, frequency of meals, substitutions and sanitary conditions and are covered by the Federal regulations in 42 CFR 483.35. The remaining provisions have been recodified in subsections (a)—(f).

In response to a comment by the PHCA that hand washing does not guarantee a food service worker will be free of communicable diseases, the Department deleted language in subsection (f) which suggested that result. The subsection now simply requires that dietary personnel practice hygienic food handling techniques.

*Section 211.7. Physician assistants and certified registered nurse practitioners.*

The last sentence in subsection (a), which stated that physician assistants and certified registered nurse practitioners (CRNPs) could not be used in lieu of physicians, was deleted as it referenced former § 211.2(b) and (c) (relating medical services), which was deleted as well. The PACAH agreed with the section as written. The University of Pennsylvania Health System's Institute on Aging argued that the section should reflect the fact that CRNPs may prescribe drugs. As subsection (a) states that CRNPs may be utilized in accordance with the requirements of their licensing statute and regulations governing their scope of practice, the Department does not believe it is necessary to specifically grant them the right to prescribe in facility licensure regulations.

*Section 211.8. Restraints.*

The Department added drug restraints to subsection (d), which requires a physician's order for the use of a restraint, and deleted former subsection (f), which did not require an order for a geriatric chair. Both amendments are consistent with Federal regulations. New subsection (f) requires an interdisciplinary team to reevaluate the need for all restraints ordered by physicians. As proposed, subsection (e) would have required the physician to review the necessity for the continued restraint every 30 days. In response to a comment by the PANPHA, the Department has revised the section by deleting that requirement in subsection (e) and adding a requirement to subsection (f) that the interdisciplinary team shall reevaluate the use of all restraints every 30 days or sooner if necessary. This section ties into § 211.11(b) (relating to resident care plan), which requires the individual charged with coordinating the resident care plan to be part of the interdisciplinary team. The review may be sooner than every 30 days based on the interdisciplinary team's assessment of the resident.

Both Good Shepherd and Lehigh County Home commented that the Federal requirement of quarterly reports by the interdisciplinary team would be sufficient. The Department wants to encourage restraint reduction. It believes that a more frequent periodic review by the interdisciplinary team will assist facilities with this initiative.

St Mary's Home of Erie questioned whether the physician would have to attend the interdisciplinary team meeting. It is not mandatory that the physician attend the meetings, however, as an essential member of the team, the physician must have input into and review the team report and any recommendations therein to discontinue restraint usage.

The Philadelphia Geriatric Center questioned what the Department meant by a chemical restraint in subsection (d) as proposed. The Department has included a revised definition that specifically includes chemical restraints in § 201.3 (relating to definitions), and deleted the words "physical or chemical" in subsection (d). Instead, it included the word "drug" along with the list of physical restraints which require a physician's order. One commentator suggested the Department clarify that the use of a drug be for purposes of restraint in subsection (d). The Department has not done so as it believes that the wording is clear.

Lehigh County Home also commented that the pharmacist rather than the interdisciplinary team was the expert on chemical restraints and should review these orders instead of the interdisciplinary team. The Department believes that the pharmacist should have input in these situations and should either consult with or be a part of the interdisciplinary team.

A nursing home administrator suggested that the regulations permit the use of side rails and not consider them a restraint, because families often request them. The Department recognizes that families may request side rails, but the Department views side rails as a potential restraint and has not exempted them in these regulations. Facilities need to communicate to families the potential effect that the use of side rails or any restraint may have on the resident. The HCFA considers side rails to be a restraint as well.

*Section 211.9. Pharmacy services.*

The Department has eliminated the provisions in subsection (a) which provided that the facility have written policies and procedures for ensuring the identity of the resident and recording of medication administration. These requirements are covered by the Federal regulation in 42 CFR 483.60(a), which states that the facility must assure accurate administration of all drugs. PANPHA suggested that subsection (a) (1) and (2), which requires the facility to ensure the identity of the resident prior to administering the medication and to record the dosage and time given, be retained as a safeguard. The Department rejected this recommendation. It believes that this is standard protocol and covered by the broad general wording of the Federal regulation. The Department incorporated a suggestion from HAP that the words "regarding medication administration" be added to former subsection (a)(3), now subsection (a)(1).

That part of subsection (e) which required a 30 or 60 day review of physician's orders for intermediate or

skilled care residents has been deleted to reflect the elimination of the references to skilled and intermediate care. Former subsections (f) and (g), which addressed automatic stop orders and the recording of any medications not given, as well as former subsection (i), which specified the information which needed to appear on a prescription container, have also been deleted as the Department believes these matters are adequately covered by the Federal regulations which address labeling requirements, require the accurate "acquiring, receiving, dispensing, and administering" of all pharmaceuticals, and specifically address labeling of drugs.

Former subsection (h), which addressed oral orders for medications, has been moved to § 211.3 (relating to oral and telephone orders) as suggested by the PANPHA.

The Department added the provisions of provider Bulletin No. 53, issued in January 1998, to former subsection (j), now subsection (f), which permits a resident to use an outside pharmacy as long as the pharmacy complies with applicable regulations and facility policies. Subsections (f)(1)—(4), which address the facility's responsibilities when residents choose outside pharmacies, have been added to the proposed language.

The Department proposed to delete former subsection (k), now subsection (g), which addressed the labeling and handling of over-the-counter drugs. The Department agrees with a suggestion from Good Shephard that this subsection be retained.

The Department has revised former subsection (m), now subsection (i), to require the return of outdated or deteriorated medications to the issuing pharmacy on at least a quarterly basis. St. Mary's Home of Erie suggested the requirement that these drugs be returned to the issuing pharmacy be eliminated. However, the Department feels this is the proper means of disposing and accounting for these medications.

Former subsection (o), which required the facility to have policies regarding the pharmacist's duties and the pharmaceutical committee's role, has been deleted as well, since the Federal regulation addresses service consultation and the role of the pharmacist in the facility.

Former subsection (p), which addressed experimental use of drugs, has been deleted as the subsection simply referenced a Federal regulation addressing experimental use of drugs. Former subsection (q) has been deleted, as its requirements for storage of drugs and biologicals is dealt with in 42 CFR 483.60(e).

The Department has amended former subsection (r), now subsection (k), which outlined the duties of the pharmaceutical services committee. The subsection provides that the oversight of the pharmaceutical services in the facility is the responsibility of the quality assurance committee. Good Shephard and the Pennsylvania Long-Term Pharmacists Coalition were concerned that this amendment could be interpreted as eliminating the pharmacist's role in reviewing drug regimens and the pharmacy committee's role in the oversight of pharmaceutical services in the facility. This was not the Department's intent. Facilities are encouraged to appoint a pharmacist to the quality assurance committee. New language has been added to subsection (k) which requires that the quality assurance committee seek input from the pharmacist in developing written procedures for administration and control of drugs, and in overseeing the pharmaceutical services within the facility. Facilities may continue to operate pharmaceutical services committees which may function separately or as an integral part of the quality assurance committee. Further, the Federal language in 42 CFR 483.60(c) specifically provides that each resident's drug regimen is to be reviewed monthly by a licensed pharmacist.

*Section 211.10. Resident care policies and 211.11. Resident care plan.*

The Department has deleted former subsections (a), (b) and (d)—(f) of § 211.10, which required a facility to have resident care policies and former subsections (d) and (e) of § 211.11, which provided that resident care plans are to be interdisciplinary and are to set goals to be utilized by the care team. Federal regulations in 42 CFR 483.20(d) address the requirements of resident care plans and the role of the interdisciplinary care team. The portion of § 211.10(c) which addressed what specifics must be included in resident care policies has been deleted as well.

The Department has revised subsections (a)—(c) of § 211.11. Subsection (a) had required a registered nurse (RN) to develop the care plan. The amended language does not limit facilities to using an RN, but states that the facility shall designate an individual to be responsible for the coordination and implementation of the care plan. Subsection (b) requires the individual to be a member of the interdisciplinary team.

The PNA objected to the proposed amendment to subsection (a) and urged the Department to retain the RN requirement. The Department felt that the facility should still have the flexibility to use an individual other than an RN as an overall coordinator, but added specific language to subsection (c) which provides that the RN is responsible for developing the nursing assessment portion of the resident care plan. This is consistent with 42 CFR 483.20(c)(1)(ii), which states that an RN is responsible for signing and certifying the information on the resident assessment instrument used to develop the care plan.

Although the Department proposed to delete former subsection (g), which provides that the resident shall participate in the development and review of the resident's care plan, it has reconsidered the matter and is retaining the subsection as subsection (e).

*Section 211.12. Nursing services.*

The Department has amended subsection (a), which required nursing services to meet the needs of residents, to reflect the Federal language in 42 CFR 483.30(a) which requires nursing services to meet the needs of residents on a 24-hour basis. The PNA suggested that nursing care be under the direction of an RN at all times. Although new subsection (f)(1) permits a facility to use an LPN on the night tour of duty in facilities having a census of 59 or less, subsection (f)(2) requires a registered nurse to be on call and proximate to the facility in such a situation.

Former subsection (d), which required that if a director of nursing has institutional responsibilities other than nursing an RN shall serve as an assistant, has been deleted. The PACAH objected to the proposed deletion as it feels an assistant is necessary to ensure that someone will be serving as a director of nursing at all times. The Department believes that the requirement of a full time director of nursing is clearly set forth in subsection (b) and implied by the other provisions of this section which describe the director of nursing's responsibility and accountability. Facilities may hire registered nurses to assist the director of nursing if necessary.

Former subsection (g), now subsection (e), required that a facility designate a "charge nurse" to supervise all nursing activities. In response to a comment from a

facility that the term "charge nurse" should be "supervisor," the Department has changed the wording to state that the facility shall designate an RN to oversee nursing activities on all tours of duty. The PHCA questioned whether this would still permit the use of an LPN as charge nurse on the night tour of duty in facilities of 59 or less. This is still permitted as long as the RN is available as set forth in subsection (f)(2).

Former subsection (e), now subsection (d), is amended to delete former requirements that the director of nursing be responsible for nursing service objectives, job descriptions, scheduling rounds and staff development. The Department did not feel it had to mandate that these particular assignments be performed by the director of nursing only. The director of nursing is still responsible for standards of accepted nursing practice, written job descriptions for nursing personnel, coordination of nursing services with other resident services, recommendations for staffing levels and general supervision of nursing services. The PNA's comments reflect that it agrees with continuing to designate these delineated duties being assigned to the director of nursing.

Former subsections (f) and (i) have been deleted. They addressed supervision of nursing services and minimum staffing ratios through July 1, 1988.

The Department has amended the general number of nursing hours in former subsection (n), now subsection (i), to eliminate the distinctions between skilled and intermediate care. By statement of policy dated February 17, 1996, the Department set the requirement at 2.3 hours of nursing care per resident in a 24-hour period. This subsection implements this statement of policy as revised. This is a minimum requirement. Any quality of care deficiencies will be cited even if facilities meet the minimum staffing ratio.

Many commentators, including IRRC, Senator Kukovich and former Senator Williams, Representatives Casorio and Veon, PNA, PANPHA, the Pennsylvania AFL/CIO, United Church of Christ Homes, the Lehigh County Home, St. Mary's Home of Erie, SEIU and the Pennsylvania Health Law Project, expressed their belief that the 2.3 minimum number of hours was too low. The commentaters felt that acuity levels have been rising in long-term care nursing facilities as individuals are spending less time in acute care settings before being released to a nursing home and that the minimum nurse staffing levels should reflect this. The majority of the stakeholders who commented on this provision argued that the level should be 2.7. The Department has reconsidered the issue and has revised the minimum nursing staff level to 2.7 hours of direct care for each resident.

The PACAH and the Pennsylvania AFL/CIO oppose any flat minimum rate for nursing hours. Although the Department recognizes that a flat minimum rate does not guarantee positive outcomes, it believes that it is important to set a minimum staffing level which is simply a floor that a facility may not go below. Obviously, quality is determined by many factors, but a minimum staffing level can not hurt facilities which are staffed at or above that level. The minimum level will likely help facilities which are not meeting that staffing level to avoid deficiency situations which may result from insufficient staffing.

One commentator suggested that the term "nursing unit" in new subsection (k), which requires weekly time schedules to reflect personnel by unit, be defined. The Department is reluctant to do so. It chooses to provide licensees with the flexibility to determine what constitutes a nursing unit for their own individual facility.

Subsections (r) and (s) are deleted, as nutritional needs and restorative care are addressed in the comprehensive resident assessments required by the Federal regulations in 42 CFR 483.25(d), (i) and (j).

*Section 211.13. Rehabilitative services.*

The Department has repealed this section, as this subject matter is covered by the Federal regulation in 42 CFR 483.45.

*Section 211.14. Diagnostic services.*

This section is deleted, as the subject is addressed in the Federal regulation in 42 CFR 483.75(j) and (k).

*Section 211.15. Dental services.*

The Department is deleting subsections (b)—(d) from this section as the subject matter addressed in those subsections are covered in the Federal regulation in 42 CFR 483.55. Subsection (a) is amended to require that facilities assist residents in obtaining routine and emergency dental care.

*Section 211.16. Social services.*

The Department had proposed to delete this section as the subject matter is covered in the Federal regulation in 42 CFR 483.15(g). However, the Federal requirement mandates only that social services be provided and that a social worker be employed by facilities with a census of more than 120 residents. The Department deleted the majority of the section, but added language that requires facilities with 120 beds or less that do not employ a social worker to obtain consultation with a qualified social worker.

*Section 211.17. Pet therapy.*

The Department deleted all subsections from this section addressing resident activities, except for former subsection (f) which sets forth requirements for facilities using pet therapy. Resident activities are addressed in the Federal regulation in 42 CFR 483.15(f). In response to a comment from St. Mary's Home of Erie that dining rooms are sometimes used as all purpose rooms and animals should be permitted there, the Department revised subsection (1) to prohibit animals in the dining room only when meals are being served.

*Fiscal Impact*

The final rulemaking incorporates most of the Federal certification regulations for long-term care nursing facilities. It retains only those State licensure requirements which are either not addressed by the Federal regulations or are stricter than the Federal standards but important to keep to ensure high quality of care for the citizens of this Commonwealth. The final rulemaking will not impose additional costs on the great majority of long-term care nursing facilities, which are already certified to participate in the Federal Medicare Program and therefore already need to comply with the Federal regulations that have been incorporated by reference.

The few facilities which do not participate in Medicare or MA may incur minor costs in heightened educational and training requirements for nurse aides. The adoption of 2.7 hours of direct nursing care per resident for long-term care nursing facilities should not impose an additional financial burden on these providers. The Department's statistics indicate that currently almost 90% of long-term care providers either meet or exceed this standard.

The final-form regulations eliminate the requirement that facilities file two sets of construction plans for new construction or renovation and, instead, require only one set of plans to be filed. This will save facilities time and money. Although the final-form regulations keep a basic square footage requirement for rooms, they remove many of the specific spacial dimension requirements inside those rooms. This will permit flexibility in design for new construction or renovations and thereby result in potential savings for providers.

*Paperwork Requirements*

The final-form regulations will not have a significant impact on existing reporting, recordkeeping or other paperwork requirements. This is because the Department is simply incorporating various Federal requirements that the great majority of long-term nursing care providers already satisfy.

*Effective Date/Sunset Date*

The final-form regulations will become effective upon publication in the *Pennsylvania Bulletin.*

*Statutory Authority*

Section 803 of the act (35 P. S. § 448.803), authorizes the Department to promulgate regulations necessary to carry out the purposes and provisions of the act. Section 801.1 of the act provides that the purpose of the act is to promote the public health and welfare through the establishment of regulations setting minimum standards for the operation of health care facilities. The same section provides that the minimum standards are to assure safe, adequate and efficient facilities and services and are also to promote the health, safety and adequate care of patients or residents of these facilities.

*Regulatory Review*

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on July 19, 1997, the Department submitted a copy of notice of proposed rulemaking, published at 27 Pa. B. 3609 to IRRC and the Chairpersons of the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare for review and comment.

In compliance with section 5(c) of the Regulatory Review Act, the Department also provided IRRC and the Committees with copies of the comments received, as well as other documentation.

In compliance with section 5.1(a) of the Regulatory Review Act (71 P. S. § 745.5a(a)), the Department submitted a copy of the final-form regulations to IRRC and the Committees on March 30, 1999. In addition, the Department provided IRRC and the Committees with information pertaining to commentators and a copy of a detailed Regulatory Analysis Form prepared by the Department in compliance with Executive Order 1996-1, "Regulatory Review and Promulgation." A copy of this material is available to the public upon request.

In preparing these final-form regulations the Department has considered all comments received from IRRC, the Committees and the public.

These final-form regulations were deemed approved by the House and Senate Committees on April 19, 1999 IRRC met on April 22, 1999, and approved the regulation in accordance with section 5.1(d) of the Regulatory Review Act. The Office of Attorney General approved these regulations for form and legality on July 12, 1999.

*Contact Person*

Questions regarding these final-form regulations may be submitted to: William A. Bordner, Director, Department of Health, Division of Nursing Care Facilities, P. O. Box 90, Harrisburg, PA 17108-0090, (717) 787-1816. Persons with disabilities who would like to obtain this document in an alternative format (that is, large print, audio tape, braille) should contact James T. Steele, Jr., so that the necessary arrangements can be made.

*Findings*

The Department finds that:

(1) Public notice of intention to adopt the regulations adopted by this order has been given under sections 201 and 202 of the act of July 31, 1968 (P. L. 760, No. 240) (45 P. S. §§ 1201 and 1202), and the regulations thereunder, 1 Pa. Code §§ 7.1 and 7.2.

(2) A public comment period was provided as required by law and all comments were considered.

(3) The adoption of the final-form regulations in the manner provided by this order is necessary and appropriate for the administration of the authorizing statute.

*Order*

The Department, acting under the authorizing statute, orders that:

(a) The regulations of the Department at 28 Pa. Code Chapters 201, 203, 205, 207, 209 and 211, are amended by amending §§ 201.1—201.3, 201.12—201.15, 201.18—201.20, 201.22—201.26, 201.29—201.31, 203.1, 205.1, 205.2, 205.4, 205.6—205.10, 205.12—205.14, 205.16, 205.17, 205.19—205.28, 205.31—205.33, 205.36—205.40, 205.61—205.64, 205.66—205.68, 205.71, 205.72, 205.74, 205.75, 207.2, 207.4, 209.1, 209.3, 209.7, 209.8, 211.1—211.12 and 211.15—211.17; and by deleting §§ 201.16, 201.28, 201.32, 203.2, 205.3, 205.5, 205.11, 205.15, 205.18, 205.29, 205.34, 205.35, 205.65, 205.73, 207.1, 207.3, 207.5, 209.2, 209.4—209.6, 211.13 and 211.14, to read as set forth in Annex A.

(*Editor's Note*: Sections §§ 201.11, 201.17 and 201.27 have not been amended but are being printed in Annex A for clarity. The proposed amendments to Chapters 551, 553, 555, 557, 559, 561, 563, 565, 567, 569, 571 and 573 published at 27 Pa.B. 3609 remain outstanding.)

(b) The Secretary of Health shall submit this order and Annex A to the Office of General Counsel and the Office of the Attorney General for approval as required by law.

(c) The Secretary of Health shall submit this order, Annex A and a Regulatory Analysis Form to IRRC, the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare for their review and action as required by law.

(d) The Secretary of Health shall certify this order and Annex A and deposit them with the Legislative Reference Bureau as required by law.

(e) This order shall take effect upon publication in the *Pennsylvania Bulletin.*

ROBERT S. ZIMMERMAN, Jr.,
*Secretary*

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission relating to this document, see 29 Pa.B. 2542 (May 8, 1999).)

**Fiscal Note:** 10-149A. No fiscal impact; (8) recommends adoption.

## Annex A

## TITLE 28. HEALTH AND SAFETY

## PART IV. HEALTH FACILITIES

## Subpart C. LONG TERM CARE FACILITIES

## CHAPTER 201. APPLICABILITY, DEFINITIONS OWNERSHIP AND GENERAL OPERATION OF LONG TERM CARE NURSING FACILITIES

### GENERAL PROVISIONS

Sec.
201.1. Applicability.
201.2. Requirements.
201.3. Definitions.

### OWNERSHIP AND MANAGEMENT

201.11. Types of ownership.
201.12. Application for license.
201.13. Issuance of license.
201.14 Responsibility of licensee.
201.15. Restrictions on license.
201.16. (Reserved).
201.17. Location.
201.18. Management.
201.19. Personnel policies and procedures.
201.20. Staff development.
201.21. Use of outside resources.
201.22. Prevention, control and surveillance of tuberculosis (TB).
201.23. Closure of facility.
201.24. Admission policy.
201.25. Discharge policy.
201.26. Power of attorney.
201.27. Advertisement of special services.
201.28. (Reserved).
201.29. Resident rights.
201.30. Access requirements.
201.31. Transfer agreement.
201.32. (Reserved).

### GENERAL PROVISIONS

### § 201.1. Applicability

This subpart applies to profit and nonprofit long-term care nursing facilities which provide either skilled nursing care or intermediate nursing care, or both, within the facilities under the act.

### § 201.2. Requirements.

The Department incorporates by reference Subpart B of the Federal requirements for long-term care facilities, 42 CFR 483.1—483.75 (relating to requirements for long-term care facilities) revised as of October 1, 1998, as licensing regulations for long-term care nursing facilities with the exception of the following sections and subsections:

(1) Section 483.1 (relating to basis and scope).

(2) Section 483.5 (relating to definitions).

(3) Section 483.10(b)(10), (c)(7) and (8) and (o) (relating to level A requirement: Resident rights).

(4) Section 483.12(a)(1), (b), (c)(1) and (d)(1) and (3) (relating to admission, transfer and discharge rights).

(5) Section 483.20(j) and (m) (relating to resident assessment).

(6) Section 483.30(b)—(d) (relating to nursing services).

(7) Section 483.40(e) and (f) (relating to physician services).

(8) Section 483.55 (relating to dental services).

(9) Section 483.70(d)(1)(v) and (3) (relating to physical environment).

(10) Section 483.75(e)(1), (h) and (p) (relating to administration).

### § 201.3. Definitions.

The following words and terms, when used in this subpart, have the following meanings, unless the context clearly indicates otherwise:

*Abuse*—The infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish. The term includes the following:

(i) *Verbal abuse*—Any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend or disability. Examples of verbal abuse include:

(A) Threats of harm.

(B) Saying things to frighten a resident, such as telling a resident that the resident will never be able to see his family again.

(ii) *Sexual abuse*—Includes sexual harassment, sexual coercion or sexual assault.

(iii) *Physical abuse*—Includes hitting, slapping, pinching and kicking. The term also includes controlling behavior through corporal punishment.

(iv) *Mental abuse*—Includes humiliation, harassment, threats of punishment or deprivation.

(v) *Involuntary seclusion*—Separation of a resident from other residents or from his room or confinement to his room (with/without roommates) against the resident's will, or the will of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs.

(vi) *Neglect*—The deprivation by a caretaker of goods or services which are necessary to maintain physical or mental health.

*Act*—The Health Care Facilities Act (35 P. S. §§ 448.101—448.904).

*Administration of drugs*—The giving of a dose of medication to a patient as a result of an order of a practitioner licensed by the Commonwealth to prescribe drugs.

*Administrator*—An individual who is charged with the general administration of a facility, whether or not the individual has an ownership interest in the facility and whether or not the individual's functions and duties are shared with one or more other individuals. The administrator shall be currently licensed and registered by the Department of State under the Nursing Home Administrators License Act (63 P. S. §§ 1101—1114.2).

*Alteration*—An addition, modification or modernization in the structure or usage of a building or section thereof or change in the services rendered.

*Ambulatory patient*—An individual who is physically and mentally capable of getting in and out of bed and walking a normal path to safety in a reasonable period of time, including the ascent and descent of stairs without the aid of another person.

*Ambulatory resident*—An individual who is physically and mentally capable of getting in and out of bed and walking a normal path to safety in a reasonable period of time, including the ascent and descent of stairs without the aid of another person.

*Audiologist*—A person licensed as an audiologist by the Pennsylvania State Board of Examiners in Speech-Language and Hearing, or excluded from the requirement of licensure under the Speech-Language and Hearing Licensure Act (63 P. S. §§ 1701—1719).

*Authorized person to administer drugs and medications*—Persons qualified to administer drugs and medications in facilities are as follows:

(i) Physicians and dentists who are currently licensed by the Bureau of Professional and Occupational Affairs, Department of State.

(ii) Registered nurses who are currently licensed by the Bureau of Professional and Occupational Affairs, Department of State.

(iii) Practical nurses who have successfully passed the State Board of Nursing examination.

(iv) Practical nurses licensed by waiver in this Commonwealth who have successfully passed the United States Public Health Service Proficiency Examination.

(v) Practical nurses licensed by waiver in this Commonwealth who have successfully passed a medication course approved by the State Board of Nursing.

(vi) Student nurses of approved nursing programs who are functioning under the direct supervision of a member of the school faculty who is present in the facility.

(vii) Recent graduates of approved nursing programs who possess valid temporary practice permits and who are functioning under the direct supervision of a professional nurse who is present in the facility. The permits shall expire if the holders of the permits fail the licensing examinations.

(viii) Physician assistants and registered nurse practitioners who are certified by the Bureau of Professional and Occupational Affairs.

*Basement*—A story or floor level below the main or street floor. If, due to grade differences, there are two levels qualifying as a street floor, a basement is a floor below the lower of the two street floors.

*CRNP—Certified Registered Nurse Practitioner*—A registered nurse licensed in this Commonwealth who is certified by the State Board of Nursing and the State Board of Medicine as a CRNP, under the Professional Nursing Law (63 P. S. §§ 211—225) and the Medical Practice Act of 1985 (63 P. S. §§ 422.1—422.45).

*Charge nurse*—A person designated by the facility who is experienced in nursing service administration and supervision and in areas such as rehabilitative or geriatric nursing or who acquires the preparation through formal staff development programs and who is licensed by the Commonwealth as one of the following:

(i) A registered nurse.

(ii) A registered nurse licensed by another state as a registered nurse and who has applied for endorsement from the State Board of Nursing and has received written notice that the application has been received by the State Board of Nursing. This subparagraph applies for 1 year, or until Commonwealth licensure is completed, whichever period is shorter.

(iii) A practical nurse who is a graduate of a Commonwealth recognized school of practical nursing or who has 2 years of appropriate experience following licensure by waiver as a practical nurse.

(iv) A practical nurse shall be designated by the facility as a charge nurse only on the night tour of duty in a facility with a census of 59 or less.

*Clinical laboratory*—A place, establishment or institution, organized and operated primarily for the performance of bacteriological, biochemical, hematological, microscopical, serological or parasitological or other tests by the practical application of one or more of the fundamental sciences to material originating from the human body, by the use of specialized apparatus, equipment and methods, for the purpose of obtaining scientific data which may be used as an aid to ascertain the state of health. The tests are conducted using specialized apparatus, equipment and methods, for the purpose of obtaining scientific data which may be used as an aid to ascertain the state of health.

*Clinical records*—Facility records, whether or not automated, pertaining to a resident, including medical records.

*Controlled substance*—A drug, substance or immediate precursor included in Schedules I—V of the Controlled Substance, Drug, Device and Cosmetic Act (35 P. S. §§ 780-101—780-144).

*Corridor*—A passageway, hallway or other common avenue used by patients and personnel to travel between buildings or sections of the same building to reach a common exit or service area. The service area includes, but is not limited to, living room, kitchen, bathroom, therapy rooms and storage areas not immediately adjoining the patient's sleeping quarters.

*Department*—The Department of Health of the Commonwealth.

*Dietetic service supervisor*—A person who meets one of the following requirements:

(i) Is a dietitian.

(ii) Is a graduate of a dietetic technician or dietetic assistant training program, correspondence course or classroom course approved by the American Dietetic Association.

(iii) Is a member of the American Dietetic Association or the Dietary Managers Association.

(iv) Is a graduate of a State approved course that provided 90 or more hours of classroom instruction in food service supervision and has experience as a supervisor in a health care institution with consultation from a dietitian.

(v) Has training and experience in food service supervision and management in a military service equivalent in content to the program in subparagraph (iv).

(vi) Has a baccalaureate degree from a State approved or accredited college or university and has at least 12 credit hours in food service, nutrition or diet therapy and at least 1 year of supervisory experience in the dietary department of a health care facility.

*Dietitian*—A person who is either:

(i) Registered by the Commission on Dietetic Registration of the American Dietetic Association.

(ii) Eligible for registration and who has a minimum of a bachelor's degree from a United States regionally

accredited college or university and has completed the American Dietetic Association (ADA) approved dietetic course requirements and the requisite number of hours of ADA approved supervised practice.

*Director of nursing services*—A registered nurse who is licensed and eligible to practice in this Commonwealth and has 1 year of experience or education in nursing service administration and supervision, as well as additional education or experience in areas such as rehabilitative or geriatric nursing, and participates annually in continuing nursing education. The director of nursing services is responsible for the organization, supervision and administration of the total nursing service program in the facility.

*Drug administration*—An act in which a single dose of a prescribed drug or biological is given to a patient by an authorized person in accordance with statutes and regulations governing the act. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container, verifying it with the physician's orders, giving the individual dose to the proper patient and promptly recording the time and dose given.

*Drug dispensing*—An act by a practitioner or a person who is licensed in this Commonwealth to dispense drugs under the Pharmacy Act (63 P. S. §§ 390-1—390-13) entailing the interpretation of an order for a drug or biological and, under that order, the proper selecting, measuring, labeling, packaging and issuance of the drug or biological for a patient or for a service unit of the facility.

*Drug or medication*—A substance meeting one of the following qualifications:

(i) Is recognized in the official United States Pharmacopeia, or official National Formulary or a supplement to either of them.

(ii) Is intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals.

(iii) Is other than food and intended to affect the structure or a function of the human body or other animal body.

(iv) Is intended for use as a component of an article specified in subparagraph (i), (ii) or (iii), but not including devices or their components, parts or accessories.

*Elopement*—When a resident leaves the facility without the facility staff being aware that the resident has done so.

*Existing facility*—A long-term care nursing facility or section thereof which was constructed and licensed as such on or before July 24, 1999.

*Exit* or *exitway*—A required means of direct egress in either a horizontal or vertical direction leading to the exterior grade level.

*Facility*—A licensed long-term care nursing facility as defined in Chapter 8 of the act (35 P. S. §§ 448.801—448.821).

*Full-time*—A minimum of a 35-hour work week involving a minimum of 4 days per week.

*Interdisciplinary team*—A team including the resident's attending physician, a registered nurse with responsibility for the resident and other appropriate staff in disciplines as determined by the resident's needs, and the resident. If the resident is cognitively impaired and unable to fully participate, the team shall include to the extent practicable, the participation of the resident, and shall also include the resident's family, a responsible person or the resident's legal representative.

*Licensed practical nurse*—A practical nurse licensed to practice under the Practical Nurse Law (63 P. S. §§ 651—667.8).

*Licensee*—The individual, partnership, association or corporate entity including a public agency or religious or fraternal or philanthropic organization authorized to operate a licensed facility.

*Locked restraints*—A mechanical apparatus or device employed to restrict voluntary movement of a person not removable by the person. The term includes shackles, straight jackets and cage-like enclosures and other similar devices.

*Medical record practitioner*—A person who is certified or eligible for certification as a registered records administrator (RRA) or a health information technologist/accredited record technician by the American Health Information Management Association (AHIMA) and who has the number of continuing education credits required for each designation by the AHIMA.

*NFPA*—National Fire Protection Association.

*Nonambulatory resident*—A resident who is not physically or mentally capable of getting in and out of bed and walking a normal path to safety in a reasonable period of time, including the ascent and descent of stairs, without the aid of another person.

*Nonproprietary drug*—A drug containing a quantity of controlled substance or drug requiring a prescription, a drug containing biologicals or substances of glandular origin—except intestinal-enzymes and liver products—and drugs which are administered parenterally.

*Nurse aide*—An individual providing nursing or nursing-related services to residents in a facility who:

(i) Does not have a license to practice professional or practical nursing in this Commonwealth.

(ii) Does not volunteer services for no pay.

(iii) Has met the requisite training and competency evaluation requirements as defined in 42 CFR 483.75 (relating to administration).

(iv) Appears on the Commonwealth's Nurse Aide Registry.

(v) Has no substantiated findings of abuse, neglect or misappropriation of resident property recorded in the Nurse Aide Registry.

*Nursing care*—A planned program to meet the physical and emotional needs of the patient. The term includes procedures that require nursing skills and techniques applied by properly trained personnel.

*Nursing service personnel*—Registered nurses, licensed practical nurses and nurse aides.

*Occupational therapist*—A person licensed as an occupational therapist by the State Board of Occupational Therapy Education and Licensure.

*Occupational therapy assistant*—A person licensed as an occupational therapy assistant by the State Board of Occupational Therapy Education and Licensure.

*Patient activities coordinator*—A person who meets one of the following requirements:

(i) Is a qualified therapeutic recreation specialist.

(ii) Has 2 years of experience in a social or recreational program, within the last 5 years, 1 year of which was full-time in a patient activities program in a health care setting.

*Pharmacist*—A person licensed by the State Board of Pharmacy to engage in the practice of pharmacy.

*Pharmacy*—A place properly licensed by the State Board of Pharmacy where the practice of pharmacy is conducted.

*Physical therapist*—A person licensed as a physical therapist by the State Board of Physical Therapy.

*Physical therapy assistant*—A person registered as a physical therapy assistant by the State Board of Physical Therapy.

*Physician assistant*—An individual certified as a physician assistant by the State Board of Medicine under the Medical Practice Act of 1985 (63 P. S. §§ 422.1—422.45), or by the State Board of Osteopathic Medical Examiners under the Osteopathic Medical Practice Act (63 P. S. §§ 271.1—271.18).

*Practice of pharmacy*—The practice of the profession concerned with the art and science of the evaluation of prescription orders and the preparing, compounding and dispensing of drugs and devices, whether dispensed on the prescription of a medical practitioner or legally dispensed or provided to a consumer. The term includes the proper and safe storage and distribution of drugs, the maintenance of proper records, the participation in drug selection and drug utilization reviews and the responsibility of relating information as required concerning the drugs and medicines and their therapeutic values and uses in the treatment and prevention of disease. The term does not include the operations of a manufacturer or distributor as defined in The Controlled Substance, Drug, Device and Cosmetic Act (35 P. S. §§ 780-101—780-144).

*Prescription*—A written or verbal order for drugs issued by a licensed medical practitioner in the course of this professional practice.

*Proprietary drug*—A drug which does not contain a quantity of a controlled substance which can be purchased without a prescription and may be purchased from sources other than a pharmacy, and is usually sold under a patented or trade name.

*Registered nurse*—A nurse licensed to practice in this Commonwealth under The Professional Nursing Law (63 P. S. §§ 211—225.5).

*Resident*—A person who is admitted to a licensed long-term care nursing facility for observation, treatment, or care for illness, disease, injury or other disability.

*Residential unit*—A section or area where persons reside who do not require long-term nursing facility care.

*Responsible person*—A person who is not an employe of the facility and is responsible for making decisions on behalf of the resident. The person shall be so designated by the resident or the court and documentation shall be available on the resident's clinical record to this effect. An employe of the facility will be permitted to be a responsible person only if appointed the resident's legal guardian by the court.

*Restraint*—A restraint can be physical or chemical.

(i) A physical restraint includes any apparatus, appliance, device or garment applied to or adjacent to a resident's body, which restricts or diminishes the resident's level of independence or freedom.

(ii) A chemical restraint includes psychopharmacologic drugs that are used for discipline or convenience and not required to treat medical symptoms.

*Skilled or intermediate nursing care*—Professionally supervised nursing care and related medical and other health services provided for a period exceeding 24 hours to an individual not in need of hospitalization, but whose needs are above the level of room and board and can only be met in a long-term care nursing facility on an inpatient basis because of age, illness, disease, injury, convalescence or physical or mental infirmity. The term includes the provision of inpatient services that are needed on a daily basis by the resident, ordered by and provided under the direction of a physician, and which require the skills of professional personnel, such as, registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists or audiologists.

*Social worker*—An individual with the following qualifications:

(i) A Bachelor's Degree in social work or a Bachelor's Degree in a human services field including sociology, special education, rehabilitation counseling and psychology.

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

*Speech/language pathologist*—A person licensed as a speech/language pathologist by the State Board of Examiners in Speech-Language and Hearing, or excluded from the requirements of licensure under the Speech-Language and Hearing Licensure Act (63 P. S. §§ 1701—1719).

## OWNERSHIP AND MANAGEMENT

### § 201.11. Types of ownership.

The owner of a facility may be an individual, a partnership, an association, a corporation or combination thereof.

### § 201.12. Application for license.

(a) An application for a license to operate a facility shall be made under section 807 of the act (35 P. S. § 448.807). The application form shall be obtained from the Division of Nursing Care Facilities, Bureau of Quality Assurance, Department of Health.

(b) The following shall be submitted with the application for licensure:

(1) The names and addresses of a person who has direct or indirect ownership interest of 5% or more in the facility as well as a written list of the names and addresses of the facility's officers and members of the board of directors.

(2) If the owner is a nonprofit corporation, a complete list of the names and addresses of the officers and directors of the corporation and an exact copy of its charter and articles of incorporation which are on file with the Department of State as well as amendments or changes.

(3) If the owner is a partnership, the names and addresses of partners.

(4) The name, address and license number of the administrator.

### § 201.13. Issuance of license.

(a) A person may not maintain or operate a facility without first obtaining a license issued by the Depart-

ment. A license to operate a facility is not transferable without prior approval of the Department.

(b) A license to operate a facility will be issued when the Department receives the completed application form and the licensure fee and when, after inspection by an authorized representative of the Department, it has been determined that the necessary requirements for licensure have been met.

(c) The required fee for a license is:

| | |
|---|---|
| Regular Licenses (new or renewal) | $250 |
| Each inpatient bed in excess of 75 beds | $2 |
| Provisional I License | $400 |
| Each inpatient bed | $4 |
| Provisional II License | $600 |
| Each inpatient bed | $6 |
| Provisional III License | $800 |
| Each inpatient bed | $8 |
| Provisional IV License | $1,000 |
| Each inpatient bed | $10 |

(d) The license will be issued to the owner of a facility and will indicate the name and address of the facility, the number and types of beds authorized and the date of the valid license.

(e) A regular license will be issued when, in the judgment of the Department, there is substantial compliance with this subpart.

(f) A provisional license is governed by the following:

(1) A provisional license will be issued if there are numerous deficiencies or a serious specific deficiency and if the facility is not in substantial compliance with this subpart and the Department finds that:

(i) The applicant is taking appropriate steps to correct the deficiencies in accordance with a timetable submitted by the applicant and agreed upon by the Department.

(ii) There is no cyclical pattern of deficiencies over a period of 2 or more years.

(2) The provisional license will be issued for a specified period of time not more than 6 months. The provisional license may be renewed, at the discretion of the Department, no more than three times. Upon substantial compliance with this subpart, a regular license will be issued.

(g) The facility shall have on file the most recent inspection reports, relating to the health and safety of patients, indicating compliance with applicable State and local statutes and regulations. Upon request, the facility shall make the most recent report available to interested persons.

(h) If the Department's inspection report indicates deficiencies, the facility shall indicate in writing its plans to make corrections and specify dates by which the corrective measures will be completed. The plans are valid only upon approval by the Department.

(i) The current license shall be displayed in a public and conspicuous place in the facility.

**§ 201.14. Responsibility of licensee.**

(a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other State and local agencies responsible for the health and welfare of patients.

(b) If the services are purchased for the administration or management of the facility, the licensee is responsible for insuring compliance with this subpart, and other relevant Commonwealth regulations.

(c) The licensee through the administrator shall report to the appropriate Division of Nursing Care Facilities field office serious incidents involving residents. As set forth in § 51.3 (relating to notification). For purposes of this subpart, references to patients in § 51.3 include references to residents.

(d) In addition to the notification requirements in § 51.3, the facility shall report in writing to the appropriate division of nursing care facilities field office:

(1) Transfers to hospitals as a result of injuries or accidents.

(2) Admissions to hospitals as a result of injuries or accidents.

(e) The administrator shall notify the appropriate division of nursing care facilities field office as soon as possible, or, at the latest, within 24 hours of the incidents listed in § 51.3 and subsection (d).

(f) Upon receipt of a strike notice, the licensee or administrator shall promptly notify the appropriate Division of Nursing Care Facilities field office and keep the Department apprised of the strike status and the measures being taken to provide resident care during the strike.

(g) A facility owner shall pay in a timely manner bills incurred in the operation of a facility that are not in dispute and that are for services without which the patient's health and safety are jeopardized.

(h) The facility shall report to the Department, on forms issued by the Department, census, rate and program occupancy information as the Department may request.

**§ 201.15. Restrictions on license.**

(a) A license shall apply only to the licensure, the name of the facility and the premises designated therein. It may not be transferable to another licensee or property without prior written approval of the Department.

(b) A license becomes void without notice if any of the following conditions exist:

(1) The expiration date has been reached.

(2) There is a change in ownership and the Department has not given prior approval.

(3) There is a change in the name of the facility, and the Department has not given prior approval for the transfer of the license.

(4) There is a change in the location of the facility and the Department has not given prior approval.

(c) A final order or determination by the Department relating to licensure may be appealed by the provider of services to the Health Policy Board under section 2102(n) of The Administrative Code of 1929 (71 P. S. § 532(n)).

**§ 201.16. (Reserved).**

**§ 201.17. Location.**

The facility shall be operated as a unit reasonably distinct from the other related services, if located in a building which offers various levels of health-related services.

**§ 201.18. Management.**

(a) The facility shall have an effective governing body or designated person functioning with full legal authority and responsibility for the operation of the facility.

(b) The governing body shall adopt and enforce rules relative to:

(1) The health care and safety of the residents.

(2) Protection of personal and property rights of the residents, while in the facility, and upon discharge or after death.

(3) The general operation of the facility.

(c) The governing body shall provide the information required in § 201.12 (relating to application for license) and prompt reports of changes which would affect the current accuracy of the information required.

(d) The governing body shall adopt effective administrative and patient care policies and bylaws governing the operation of the facility in accordance with legal requirements. The administrative and patient care policies and bylaws shall be in writing; shall be dated; shall be made available to the members of the governing body, which shall ensure that they are operational; and shall be reviewed and revised, in writing, as necessary. The policies and bylaws shall be available upon request, to patients, responsible persons and for review by members of the public.

(e) The governing body shall appoint a full-time administrator who is currently licensed and registered in this Commonwealth and who is responsible for the overall management of the facility. The Department may, by exception, permit a long-term care facility of 25 beds or less to share the services of an administrator in keeping with section 3(b) of the Nursing Home Administrators License Act (63 P. S. § 1103(b)). The sharing of an administrator shall be limited to two facilities. The schedule of the currently licensed administrator shall be publicly posted in each facility. The administrator's responsibilities shall include the following:

(1) Enforcing the regulations relative to the level of health care and safety of residents and to the protection of their personal and property rights.

(2) Planning, organizing and directing responsibilities obligated to the administrator by the governing body.

(3) Maintaining an ongoing relationship with the governing body, medical and nursing staff and other professional and supervisory staff through meetings and periodic reports.

(4) Studying and acting upon recommendations made by committees.

(5) Appointing, in writing and in concurrence with the governing body, a responsible employe to act on the administrator's behalf during temporary absences.

(6) Assuring that appropriate and adequate relief personnel are utilized for those necessary positions vacated either on a temporary or permanent basis.

(7) Developing a written plan to assure the continuity of resident care and services in the event of a strike in a unionized facility.

(f) A written record shall be maintained on a current basis for each resident with written receipts for personal possessions and funds received or deposited with the facility and for expenditures and disbursements made on behalf of the resident. The record shall be available for review by the resident or resident's responsible person upon request.

(g) The governing body shall disclose, upon request, to be made available to the public, the licensee's current daily reimbursement under Medical Assistance and Medicare as well as the average daily charge to other insured and noninsured private pay residents.

(h) When the facility accepts the responsibility for the resident's financial affairs, the resident or resident's responsible person shall designate, in writing, the transfer of the responsibility. The facility shall provide the residents with access to their money within 3 bank business days of the request and in the form—cash or check—requested by the resident.

**§ 201.19. Personnel policies and procedures.**

Personnel records shall be kept current and available for each employe and contain sufficient information to support placement in the position to which assigned.

**§ 201.20. Staff development.**

(a) There shall be an ongoing coordinated educational program which is planned and conducted for the development and improvement of skills of the facility's personnel, including training related to problems, needs and rights of the residents.

(b) An employe shall receive appropriate orientation to the facility, its policies and to the position and duties. The orientation shall include training on the prevention of resident abuse and the reporting of the abuse.

(c) There shall be at least annual in service training which includes at least infection prevention and control, fire prevention and safety, accident prevention, disaster preparedness, resident confidential information, resident psychosocial needs, restorative nursing techniques and resident rights, including personal property rights, privacy, preservation of dignity and the prevention and reporting of resident abuse.

(d) Written records shall be maintained which indicate the content of and attendance at the staff development programs.

**§ 201.21. Use of outside resources.**

(a) The facility is responsible for insuring that personnel and services provided by outside resources meet all necessary licensure and certification requirements, including those of the Bureau of Professional and Occupational Affairs in the Department of State, as well as requirements of this subpart.

(b) If the facility does not employ a qualified professional person to render a specific service to be provided by the facility, it shall make arrangements to have the service provided by an outside resource, a person or agency that will render direct service to residents or act as a consultant to the facility.

(c) The responsibilities, functions and objectives and the terms of agreement, including financial arrangements and charges of the outside resource shall be delineated in writing and signed and dated by an authorized representative of the facility and the person or agency providing the service.

(d) Outside resources supplying temporary employes to a facility shall provide the facility with documentation of an employe's health status as required under § 201.22 (c)—(j) and (l)—(m) (relating to prevention, control and surveillance of tuberculosis (TB)).

**§ 201.22 Prevention, control and surveillance of tuberculosis (TB).**

(a) The facility shall have a written TB infection control plan with established protocols which address risk assessment and management, screening and surveillance

methods, identification, evaluation, and treatment of residents and employes who have a possible TB infection or active TB.

(b) Recommendations of the Centers for Disease Control (CDC), United States Department of Health and Human Services (HHS) shall be followed in treating and managing persons with confirmed or suspected TB.

(c) A baseline TB status shall be obtained on all residents and employes in the facility.

(d) The intradermal tuberculin skin test is to be used whenever skin testing is done. This consists of an intradermal injection of 0.1 ml of purified protein derivative (PPD) tuberculin containing 5 tuberculin units (TU) using a disposable tuberculin syringe.

(e) The 2-step intradermal tuberculin skin test shall be the method used for initial testing of residents and employes. If the first test is positive, the person tested shall be considered to be infected. If the first test is negative, a second test should be administered in 1—3 weeks. If the second test is positive, the person tested shall be considered to be previously infected. If the second test result is negative, the person is to be classified as uninfected.

(f) Persons with reactions of ≥10 mm or persons with symptoms suggestive of TB regardless of the size of the test reaction, shall be referred for further diagnostic studies in accordance with CDC recommendations.

(g) A written report of test results shall be maintained in the facility for each individual, irrespective of where the test is performed. Reactions shall be recorded in millimeters of induration, even those classified as negative. If no induration is found, "0 mm" is to be recorded.

(h) Skin test "negative" employes having regular contact of 10 or more hours per week with residents shall have repeat tuberculin skin tests at intervals determined by the risk of transmission in the facility. The CDC protocol for conducting a TB risk assessment in a health care facility shall be used to establish the risk of transmission.

(i) Repeat skin tests shall be required for tuberculin-negative employes and residents after any suspected exposure to a documented case of active TB.

(j) New employes shall have the 2-step intradermal skin test before beginning employment unless there is documentation of a previous positive skin reaction. Test results shall be made available prior to assumption of job responsibilities. CDC guidelines shall be followed with regard to repeat periodic testing of all employes.

(k) The intradermal tuberculin skin test shall be administered to new residents upon admission, unless there is documentation of a previous positive test.

(l) New tuberculin positive reactors (converters) and persons with documentation of a previous positive reaction, shall be referred for further diagnostic testing and treatment in accordance with current standards of practice.

(m) If an employe's chest X-ray is compatible with active TB, the individual shall be excluded from the workplace until a diagnosis of active TB is ruled out or a diagnosis of active TB is established and a determination made that the individual is considered to be noninfectious. A statement from a physician stating the individual is noninfectious shall be required.

(n) A resident with a diagnosis of TB may be admitted to the facility if:

(1) Three consecutive daily sputum smears have been negative for acid-fast bacilli.

(2) The individual has received appropriate treatment for at least 2—3 weeks.

(3) Clinical response to therapy, as documented by a physician, has been favorable.

**§ 201.23. Closure of facility.**

(a) The administrator or owner shall notify the appropriate Division of Nursing Care Facilities field office at least 90 days prior to closure.

(b) If the facility is to be closed, the licensee shall notify the resident or the resident's responsible person in writing.

(c) Sufficient time shall be given to the resident or the resident's responsible person to effect an orderly transfer.

(d) No resident in a facility may be required to leave the facility prior to 30 days following receipt of a written notice from the licensee of the intent to close the facility, except when the Department determines that removal of the resident at an earlier time is necessary for health and safety.

(e) If an orderly transfer of the residents cannot be safely effected within 30 days, the Department may require the facility to remain open an additional 30 days.

(f) The Department is permitted to monitor the transfer of residents.

(g) The licensee of a facility shall file proof of financial responsibility with the Department to insure that the facility continues to operate in a satisfactory manner for a period of 30 days following the notice of intent to close.

**§ 201.24. Admission policy.**

(a) The resident may be permitted to name a responsible person. The resident is not required to name a responsible person if the resident is capable of managing the resident's own affairs.

(b) A facility may not obtain from or on behalf of residents a release from liabilities or duties imposed by law or this subpart except as part of formal settlement in litigation.

(c) A facility shall admit only residents whose nursing care and physical needs can be provided by the staff and facility.

(d) A resident with a disease in the communicable stage may not be admitted to the facility unless it is deemed advisable by the attending physician—medical director, if applicable—and administrator and unless the facility has the capability to care for the needs of the resident.

**§ 201.25. Discharge policy.**

There shall be a centralized coordinated discharge plan for each resident to ensure that the resident has a program of continuing care after discharge from the facility. The discharge plan shall be in accordance with each resident's needs.

**§ 201.26. Power of attorney.**

Power of attorney may not be assumed for a resident by the licensee, owner/operator, members of the governing body, an employe or anyone having a financial interest in the facility unless ordered by a court of competent jurisdiction.

**201.27. Advertisement of special services.**

A facility may not advertise special services offered unless the service is under the direction and supervision of personnel trained or educated in that particular special service, such as, rehabilitation or physical therapy by a registered physical therapist; occupational therapy by a registered occupational therapist; skilled nursing care by registered nurses; special diets by a dietitian; or special foods.

**§ 201.28. (Reserved).**

**§ 201.29. Resident rights.**

(a) The governing body of the facility shall establish written policies regarding the rights and responsibilities of residents and, through the administrator, shall be responsible for development of and adherence to procedures implementing the policies.

(b) Policies and procedures regarding rights and responsibilities of residents shall be available to residents and members of the public.

(c) Policies of the facility shall be available to staff, patients, consumer groups and the interested public, including a written outline of the facility's objectives and a statement of the rights of its residents. The policies shall set forth the rights of the resident and prohibit mistreatment and abuse of the resident.

(d) The staff of the facility shall be trained and involved in the implementation of the policies and procedures.

(e) The resident or if the resident is not competent, the resident's responsible person, shall be informed verbally and in writing prior to, or at the time of admission, of services available in the facility and of charges covered and not covered by the per diem rate of the facility. If changes in the charges occur during the resident's stay, the resident shall be advised verbally and in writing reasonably in advance of the change. "Reasonably in advance" shall be interpreted to be 30 days unless circumstances dictate otherwise. If a facility requires a security deposit, the written procedure or contract that is given to the resident or resident's responsible person shall indicate how the deposit will be used and the terms for the return of the money. A security deposit is not permitted for a resident receiving Medical Assistance (MA).

(f) The resident shall be transferred or discharged only for medical reasons, for his welfare or that of other residents or for nonpayment of stay if the facility has demonstrated reasonable effort to collect the debt. Except in an emergency, a resident may not be transferred or discharged from the facility without prior notification. The resident and the resident's responsible person shall receive written notification in reasonable advance of the impending transfer or discharge. Reasonable advance notice shall be interpreted to mean 30 days unless appropriate plans which are acceptable to the resident can be implemented sooner. The facility shall inform the resident of its bed-hold policy, if applicable, prior to discharge. The actions shall be documented on the resident record. Suitable clinical records describing the resident's needs, including list of orders and medications as directed by the attending physician shall accompany the resident if the resident is sent to another medical facility.

(g) Unless the discharge is initiated by the resident or resident's responsible person, the facility is responsible to assure that appropriate arrangements are made for a safe and orderly transfer and that the resident is transferred to an appropriate place that is capable of meeting the resident's needs. Prior to transfer, the facility shall inform the resident or the resident's responsible person as to whether the facility where the resident is being transferred is certified to participate in the Medicare and MA reimbursement programs.

(h) It is not necessary to transfer a resident whose condition had changed within or between health care facilities when, in the opinion of the attending physician, the transfer may be harmful to the physical or mental health of the resident. The physician shall document the situation accordingly on the resident's record.

(i) The resident shall be encouraged and assisted throughout the period of stay to exercise rights as a resident and as a citizen and may voice grievances and recommend changes in policies and services to the facility staff or to outside representatives of the resident's choice. The resident or resident's responsible person shall be made aware of the Department's Hot Line (800) 254-5164, the telephone number of the Long-Term Care Ombudsman Program located within the Local Area Agency on Aging, and the telephone number of the local Legal Services Program to which the resident may address grievances. A facility is required to post this information in a prominent location and in a large print easy to read format.

(j) The resident shall be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care for the necessary personal and social needs.

(k) The resident shall be permitted to retain and use personal clothing and possessions as space permits unless to do so would infringe upon rights of other residents and unless medically contraindicated, as documented by his physician in the medical record. Reasonable provisions shall be made for the proper handling of personal clothing and possessions that are retained in the facility. The resident shall have access and use of these belongings.

(l) The resident's rights devolve to the resident's responsible person as follows:

(1) When the resident is adjudicated incapacitated by a court.

(2) As Pennsylvania law otherwise authorizes.

(m) The resident rights in this section shall be reflected in the policies and procedures of the facility.

(n) The facility shall post in a conspicuous place near the entrances and on each floor of the facility a notice which sets forth the list of resident's rights. The facility shall on admission provide a resident or resident's responsible person with a personal copy of the notice. In the case of a resident who cannot read, write or understand English, arrangements shall be made to ensure that this policy is fully communicated to the resident. A certificate of the provision of personal notice as required in this section shall be entered in the resident's clinical record.

(o) Experimental research or treatment in a nursing home may not be carried out without the approval of the Department and without the written approval of the resident after full disclosure. For the purposes of this subsection, "experimental research" means an experimental treatment or procedure that is one of the following:

(1) Not a generally accepted practice in the medical community.

(2) Exposes the resident to pain, injury, invasion of privacy or asks the resident to surrender autonomy, such as a drug study.

### § 201.30. Access requirements.

(a) The facility may limit access to a resident when the interdisciplinary care team has determined it may be a detriment to the care and well-being of the resident in the facility. The facility may not restrict the right of the resident to have legal representation or to visit with the representatives of the Department of Aging Ombudsman Program. A facility may not question an attorney representing the resident or representatives of the Department, or the Department of Aging Ombudsman Program, as to the reason for visiting or otherwise communicating with the resident.

(b) A person entering a facility who has not been invited by a resident or a resident's responsible persons shall promptly advise the administrator or other available agent of the facility of that person's presence. The person may not enter the living area of a resident without identifying himself to the resident and without receiving the resident's permission to enter.

### § 201.31. Transfer agreement.

(a) The facility shall have in effect a transfer agreement with one or more hospitals, located reasonably close by, which provides the basis for effective working arrangements between the two health care facilities. Under the agreement, inpatient hospital care or other hospital services shall be promptly available to the facility's residents when needed.

(b) A transfer agreement between a hospital and a facility shall be in writing and specifically provide for the exchange of medical and other information necessary to the appropriate care and treatment of the residents to be transferred. The agreement shall further provide for the transfer of residents' personal effects, particularly money and valuables, as well as the transfer of information related to these items when necessary.

### § 201.32. (Reserved).

## CHAPTER 203. APPLICATION OF LIFE SAFETY CODE FOR LONG TERM CARE NURSING FACILITIES

Sec.
203.1. Application of the *Life Safety Code*.
203.2. (Reserved).

### § 203.1. Application of the *Life Safety Code*.

A facility shall meet the applicable edition of National Fire Protection Association 101 *Life Safety Code* which is currently adopted by the Department. A facility previously in compliance with prior editions of the *Life Safety Code* is deemed in compliance with subsequent *Life Safety Codes* except renovation or new construction shall meet the current edition adopted by the Department.

### § 203.2. (Reserved).

## CHAPTER 205. PHYSICAL PLANT AND EQUIPMENT STANDARDS FOR LONG TERM CARE NURSING FACILITIES

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## BUILDINGS AND GROUNDS

### § 205.1. Location or site.

A building to be used for and by residents shall be located in areas conducive to the health and safety of the residents.

### § 205.2. Grounds.

(a) Grounds shall be adequate to provide necessary service areas and outdoor areas for residents. A facility with site limitations may provide rooftop or balcony areas if adequate protective enclosures are provided.

(b) Delivery areas, service yards or parking area shall be located so that traffic does not cross areas commonly used by residents.

### § 205.3. (Reserved).

### § 205.4. Buildings plans.

(a) There may be no new construction of a facility without the Department's approval of final plans. There may be no alterations or additions to an existing building or conversion of a building or facility made prior to the Department's approval of final plans.

(b) Plans, including architectural, mechanical and electrical plans, shall include requested changes and shall be submitted to the Department for final approval before construction, alterations or remodeling begins.

(c) The licensee or prospective licensee shall have the opportunity to present and discuss purposes and plans

concerning the requested changes indicated on the architectural plans with the Department. If differences occur and cannot be resolved, administrative hearing may be sought under 1 Pa. Code Part II (relating to General Rules of Administrative Practice and Procedure).

(d) Plans shall be resubmitted to the Department for approval if construction or alteration has not been started within 24 months from the date the plans received final approval.

(e) Plans submitted to the Department for approval shall include the following items:

(1) Wall sections and details, including stairs, location and fastening of handrails and grab bars.

(2) Mechanical and electrical drawings.

(3) Schedules of room finishes, door type and size, plumbing fixtures, electrical fixtures and special equipment, such as sterilizers, kitchen equipment and the like.

(4) Site plan—1 inch equals 40 feet—indicating new and existing structures, roads, services, walls and north arrow.

(5) Floor plans using a minimum of 1/8 inch scale.

(6) One-fourth inch scale layout: main kitchen, nurse's station, utility room, physical therapy room, occupational therapy room and the like.

(7) One-fourth inch scale layout: typical bedroom, indicating window, door, radiator, air conditioner, electrical outlets, permanent fixtures, furniture placement or other pertinent information; typical bathroom; and a toilet room.

(8) Exterior elevation.

(9) Wall section, typical.

(10) Plans shall be on drawing sheets at least 15 by 24 inches and not exceed 32 by 42 inches in size including the borders.

**§ 205.5. (Reserved).**

**§ 205.6. Function of building.**

(a) No part of a building may be used for a purpose which interferes with or jeopardizes the health and safety of residents. Special authorization shall be given by the Department's Division of Nursing Care Facilities if a part of the building is to be used for a purpose other than health care.

(b) The only persons who may reside in the facility shall be residents, employes, the licensee, the administrator or members of the administrator's immediate family.

## MINIMUM PHYSICAL PLANT STANDARDS

**§ 205.7. Basement or cellar.**

Basements or cellars may be used for storage, laundry, kitchen, heat, electric and water equipment. Approval from the Department's Division of Nursing Care Facilities shall be secured before areas may be used for other purposes, such as physical therapy, central supply, occupational therapy and the like.

**§ 205.8. Ceiling heights.**

Ceiling heights may be 7 feet 6 inches except in boiler rooms where a minimum of 30 inches shall be provided above the main boiler heater and connecting piping. Adequate headroom for convenient maintenance and other proposed operations shall be maintained below the piping.

**§ 205.9. Corridors.**

(a) Resident corridors shall have a handrail on both sides with a return to the wall at each rail ending. Handrails shall be detailed and finished for safety and shall be free from snagging. Brackets may not impede the continuous progress of hands along the railing.

(b) Corridors shall be lighted adequately during the day and night.

(c) Areas used for corridor traffic may not be considered as areas for dining, storage, diversional or social activities.

**§ 205.10. Doors.**

(a) Doors into bathrooms and toilet rooms used by residents shall be at least 36 inches wide, except for an existing facility where the minimum width of toilet room doors is 32 inches.

(b) A door to a resident room shall swing into the room.

(c) A door to a toilet room which swings into the toilet area shall be equipped with special hardware which permits the door to be opened from the outside, and swing out, in case of emergency.

(d) Resident and visitor toilet stall doors shall swing out. Curtains or equivalent shall be considered as meeting this requirement.

(e) A door to a basement or a cellar may not be located in a resident room.

(f) A door opening to the exterior, which may be opened occasionally for ventilation purposes, with the exception of an approved exit door, shall be effectively covered with screening.

**§ 205.11. (Reserved).**

**§ 205.12. Elevators.**

(a) Elevator service shall be provided for residents when a resident use area is located above or below the first floor or grade level entrance in a building constructed or converted for use after January 1975 as a facility providing either skilled or intermediate care.

(b) The cab platform of an elevator shall measure no less than 5 feet by 7 feet 6 inches. Cab and shaft door may have not less than a 44 inch opening and shall be power operated.

**§ 205.13. Floors.**

(a) Floors traveled by residents shall be of nonskid material.

(b) Floors in the kitchen, bathroom, toilet rooms, shower rooms, utility rooms, bedpan and hopper rooms shall be of nonskid, nonabsorbent materials and easily cleanable.

**§ 205.14. Locks.**

Doors into rooms used by residents may not be locked from the outside when the resident is in the room.

**§ 205.15. (Reserved).**

**§ 205.16. Stairs.**

Stairs used by residents shall have no locked gates or free swinging doors obstructing ascent or descent.

**§ 205.17. Stairways.**

There shall be indoor stairs and stairways to a basement if the stairs are to be used by personnel of the facility.

**§ 205.18. (Reserved).**

**§ 205.19. Windows and windowsills.**

(a) Window openings in the exterior walls that are used for ventilation shall be effectively covered by screening.

(b) Rooms with windows opening onto light or air shafts, or onto an exposure where the distance between the building or an obstruction higher than the windowsill is less than 20 feet may not be used for resident bedrooms.

**§ 205.20. Resident bedrooms.**

(a) A bed for a resident shall be placed only in a bedroom approved by the Department.

(b) The maximum number of residents who may be accommodated in the facility shall be indicated on the license.

(c) The number of resident bedrooms and the number of beds in a room may not exceed the maximum number approved by the Department.

(d) Single bed bedrooms shall provide minimum room area clearance, in addition to the area of closets, vestibule, wardrobes and toilet rooms, of 100 square feet.

(e) Single resident bedrooms in facilities licensed prior to January 1975, shall contain at least 80 square feet of space.

(f) A multibed bedroom shall provide minimum room area clearances, in addition to the area of closets, vestibule, wardrobes and toilet rooms of 80 square feet per bed.

(g) In facilities licensed prior to January 1975, resident multibed bedrooms shall have at least 65 square feet of space per resident.

**§ 205.21. Special care room.**

(a) Provisions shall be made for isolating a resident as necessary in a single room which is ventilated to the outside as set forth in § 205.66 (relating to special ventilation requirements for new construction). For new construction, there shall be an adjoining private bathroom which contains a toilet, lavatory and either a standard size tub or a shower.

(b) Provisions shall be available to identify this room with appropriate precautionary signs.

**§ 205.22. Placement of beds.**

A bed may not be placed in proximity to radiators, heat vents, air conditioners, direct glare of natural light or drafts unless adequate provisions are made for resident comfort and safety.

**§ 205.23. Location of bedrooms.**

A resident bedroom shall have adjoining toilet facilities and shall be located conveniently near bathing facilities, except for those facilities licensed prior to January 1975.

**§ 205.24. Dining room.**

(a) There shall be a minimum dining area of 15 square feet per bed for the first 100 beds and 13 1/2 square feet per bed for beds over 100. This space is required in addition to the space required for lounge and recreation rooms. These areas shall be well lighted and well ventilated.

(b) Tables and space shall be provided to accommodate wheelchairs with trays and other devices.

**§ 205.25. Kitchen.**

(a) There shall be at least one kitchen large enough to meet the needs of the facility.

(b) A service pantry shall be provided for each nursing unit. The pantry shall contain a refrigerator, device for heating food, sink, counter and cabinets. For existing facilities, a service pantry shall be provided for a nursing unit unless the kitchen is sufficiently close for practical needs and has been approved by the Department.

**§ 205.26. Laundry.**

(a) A laundry room shall be provided in a facility where commercial laundry service is not used for the washing of soiled linens.

(b) The entrance and exit to the laundry room shall be located to prevent the transportation of soiled or clean linens through food preparation, food storage or food serving areas.

(c) The facility shall have a separate room for central storage of soiled linens. The room shall be well ventilated, constructed of materials impervious to odors and moisture and easily cleaned. Soiled linens may not be transported through areas where clean linen is stored.

(d) A facility shall provide a separate room or area for central storage of clean linens and linen carts.

(e) Equipment shall be made available and accessible for residents desiring to do their personal laundry.

**§ 205.27. Lounge and recreation rooms.**

There shall be a minimum of 15 square feet of floor space per bed for recreation or lounge rooms provided for the first 100 beds and 13 1/2 square feet for all beds over 100. There shall be recreation or lounge rooms for residents on each floor.

**§ 205.28. Nurses' station.**

(a) A nurses' station shall be located in each nursing unit, located as centrally as practical within the nursing unit. A common nurses' station serving more than a single nursing unit may be permitted when the design of the project and method of operation indicate a satisfactory level of service. The size and facilities of the nurses' station shall be increased appropriate to the number of beds served and additional staffing required.

(b) The nurses' station may not be more than 120 feet from the most remote resident room served.

(c) The nurses' station shall have facilities for:

(1) A nurses' call system.

(2) Charting and supplies.

(3) Medication storage and preparation, which may be within the clean workroom, if a self-contained cabinet is provided. The medication storage cabinet shall be locked. Mechanical ventilation shall be provided in this workroom. If a medication cart is used, provisions shall be made to lock the cart or to place the cart when not in use in a safe area that can be locked. The cart may not be stored in the corridor.

(4) A double-locked narcotic compartment within the medication area.

**§ 205.29. (Reserved).**

**§ 205.31. Storage.**

General storage space shall be provided for storage of supplies, furniture, equipment, residents' possessions and the like. Space provided for this purpose shall be com-

mensurate with the needs of the nursing facility, but may not be less than 10 square feet per bed.

**§ 205.32. Janitor closet.**

(a) At least one janitor closet shall be provided in a unit. If physical arrangement permits, one janitor's closet may serve more than one nursing unit or wing.

(b) A separate janitor's closet is required for the kitchen.

**§ 205.33. Utility room.**

(a) Provisions shall be made in each nursing unit near the nurses' station for utility rooms. The area shall have separate soiled and clean workrooms. The rooms may not be more than 120 feet from the most remote room served. If one nursing station services several resident corridors, a soiled utility room shall be on each unit.

(b) Facilities for flushing and rinsing bedpans, such as a spray attachment for the clinical sink or a separate bedpan flusher, shall be provided in the soiled workroom of each nursing unit, unless bedpan flushing devices, together with bedpan lugs on toilets are provided in each resident's toilet for this purpose.

(c) Hand-washing facilities shall be available in the soiled and clean utility rooms.

**§ 205.34. (Reserved).**

**§ 205.35. (Reserved).**

**§ 205.36. Bathing facilities.**

(a) The facility shall provide a general bathing area in each nursing unit to serve residents' bedrooms which do not have adjoining bathrooms with a bathtub or shower.

(b) Bathing fixtures for either the tub or shower shall be provided at a ratio of one fixture per 15 beds or major fraction thereof.

(c) Unless bathing fixtures are located in a separate room, there shall be compartments to permit privacy. Cubicle curtains may provide this privacy.

(d) Each room or compartment shall provide space for the use of bathing fixtures, wheelchairs and dressing. Sufficient space shall be provided for the attendant who may need to assist the resident.

(e) Each bathing room shall include a toilet and lavatory. If more than one tub or shower is in the bathing room, privacy shall be provided at each bathing facility and at the toilet.

(f) Showers designed for wheelchair use may be no less than 4 feet square, shall be without curbs and shall have handrails and curtains.

(g) Water controls for handicapped shower areas shall be located outside the shower stall. Other shower areas may have standard installation of shower controls.

(h) The facility shall have at least one bathtub in each centralized bath area on each floor that is accessible from three sides with a minimum of 3 feet clearance on each side and 4 feet clearance from the foot of the tub to adjacent wall or obstruction.

**§ 205.37. Equipment for bathrooms.**

(a) Grab bars shall be installed as necessary at each tub and shower for safety and convenience. Grab bars, accessories and anchorage shall have sufficient strength to sustain a weight of 250 pounds for 5 minutes.

(b) The general bathroom or shower room used by residents shall be provided with one emergency signal bell located in close proximity to the tub or shower and which registers at the nursing station. This is in addition to the emergency signal bell located at each toilet unless a single bell can be reached by the resident from both the toilet and tub or shower.

(c) Provisions shall be made available to get residents in and out of bathtubs in a safe way to prevent injury to residents and personnel. The facility shall provide appropriate supervision and assistance to ensure the safety of all residents being bathed.

(d) A dressing area shall be provided immediately adjacent to the shower stall and bathtub. In the dressing area, there shall be provisions for keeping clothes dry while bathing.

(e) The facility shall ensure that water for baths and showers is at a safe and comfortable temperature before the resident is bathed.

**§ 205.38. Toilet facilities.**

(a) In toilet rooms that adjoin resident bedrooms, there shall be at least one toilet for four residents. This shall be directly accessible from bedrooms without entering the general corridor. In no case may one toilet service more than two bedrooms. The minimum dimension of a patient toilet room containing only a toilet shall be 3 feet by 6 feet.

(b) There may be no less than 3 1/2 feet of space from front of toilet to opposite wall or fixtures.

(c) There shall be at least one toilet on each floor to accommodate patients in wheelchairs.

(d) At least one toilet room shall be provided for toilet training. This room shall be accessible from the nursing corridor and may serve the bathing area. Minimum dimensions for a toilet-training room containing only a toilet shall be 5 feet by 6 feet.

(e) Floors or units with more than eight residents of both sexes shall be provided with separate toilet fixtures in a ratio of 1:4 or major fraction thereof for each sex. In existing facilities, overall toilet fixtures shall be provided in a ratio of 1:8 or major fraction thereof for each bed.

(f) Toilets and lavatories other than resident facilities shall be provided for male and female visitors in facilities.

**§ 205.39. Toilet room equipment.**

(a) Toilet rooms shall be provided with lavatory, soap or soap dispenser, paper towels, mechanical dryer or other sanitary means of toweling. In toilet rooms adjacent to bedrooms, the lavatory may be omitted if provided in each bedroom.

(b) Toilets used by residents shall be provided with handrails or assist bars on each side capable of sustaining a weight of 250 pounds and an emergency call bell within reaching distance.

**§ 205.40. Lavatory facilities.**

(a) A floor occupied by residents shall have lavatories in the ratio of 1:4 residents or major fraction thereof. In existing facilities, lavatory fixtures shall be provided in a ratio of 1:8 or major fraction thereof for each bed.

(b) A mirror shall be over each lavatory used by residents.

## MECHANICAL AND ELECTRICAL REQUIREMENTS

### § 205.61. Heating requirements for existing and new construction.

(a) The heating system shall comply with local and State codes. If there is a conflict, the more stringent requirements shall apply.

(b) Exposed heating pipes, hot water pipes or radiators in rooms and areas used by residents or within reach of residents, shall be covered or protected to prevent injury or burns to residents. This includes hot water or steam piping above 125°F.

### § 205.62. Special heating requirements for new construction.

(a) Boiler feed pumps, heat circulating pumps, condensate return pumps and fuel oil pumps shall be connected and installed so that the total load can be carried by the remaining pumps with one pump out of service.

(b) To prevent shutting down the entire system when repairs are required, supply and return mains and risers of cooling, heating and process steam systems shall be valved to isolate the various sections of the system. Each piece of equipment shall be valved at the supply and return.

### § 205.63. Plumbing and piping systems required for existing and new construction.

(a) Potable ice may not be manufactured or stored in the soiled utility room.

(b) Water distribution systems shall be designed and arranged to provide potable hot and cold water at hot and cold water outlets at all times. The system pressure shall be sufficient to operate fixture and equipment during maximum demand periods.

(c) Hot water outlets accessible to residents shall be controlled so that the water temperature of the outlets does not exceed 110°F.

### § 205.64. Special plumbing and piping systems requirements for new construction.

(a) Plumbing systems shall be installed to meet the requirements of local plumbing codes and Chapter 14, Medical Care Facility Plumbing Equipment, of the *PHCC National Standard Plumbing Code.* Sections 14.22 and 14.23 of the *PHCC National Standard Plumbing Code* are not mandatory, but are recommended. If the codes listed in this subsection conflict, the most stringent requirement shall apply.

(b) Approved backflow preventers or vacuum breakers shall be installed with plumbing fixtures or equipment where the potable water supply outlet may be submerged and which is not protected by a minimum air gap. This includes hose bibs, janitor sinks, bedpan-flushing attachments and other fixtures to which hoses or tubing can be attached.

(c) Each water service main, branch main, riser and branch to a group of fixtures shall be valved. Stop valves shall be provided at each fixture.

(d) Shower bases and tubs shall provide nonskid surfaces for standing residents.

### § 205.65. (Reserved).

### § 205.66. Special ventilation requirements for new construction.

(a) Ventilation for new construction shall conform to the following:

| *Area Designation* | *Pressure Relationship to Adjacent Areas* | *Minimum Air Changes of Outdoor Air Per Hour* | *Minimum Total Air Changes Per Hour* | *All Air Directly to Outdoors* | *Recirculated within Room Units* |
|---|---|---|---|---|---|
| Resident Room | Equal | 2 | 2 | Optional | Optional |
| Resident Area Corridor | Equal | Optional | 2 | Optional | Optional |
| Physical therapy | Negative | 2 | 6 | Optional | Optional |
| Occupational therapy | Negative | 2 | 6 | Optional | Optional |
| Soiled workroom or soiled holding | Negative | 2 | 10 | Yes | No |
| Clean workroom or clean holding | Positive | 2 | 4 | Optional | Optional |
| Toilet room | Negative | Optional | 10 | Yes | No |
| Bathroom | Negative | Optional | 10 | Yes | No |
| Janitor's closet | Negative | Optional | 10 | Yes | No |
| Sterilizer equipment room | Negative | Optional | 10 | Yes | No |
| Linen and trash chute rooms | Negative | Optional | 10 | Yes | No |
| Food preparation center | Equal | 2 | 10 | Yes | Yes |
| Warewashing room | Negative | Optional | 10 | Yes | Yes |
| Dietary day storage | Equal | Optional | 2 | Yes | No |
| Laundry, general | Equal | 2 | 10 | Yes | No |
| Soiled linen sorting and storage | Negative | Optional | 10 | Yes | No |
| Clean linen storage | Positive | Optional | 2 | Yes | No |
| Special Care Room/Isolation | Negative | 2 | 6 | Yes | No |

(b) Central air systems shall be provided with filters having a minimum efficiency of 25% based on ASHRAE Standard No. 52-68 and certified by an independent testing agency. Central air systems shall have a manometer installed across each filter bed.

(c) Air supply systems shall be operated mechanically. Air exhaust and return systems shall be operated mechanically, except for air not required to be exhausted directly outdoors as indicated in subsection (a). Where subsection (a) requirements for outdoor air is optional, this air may be supplied directly by transfer ducts or grilles to adjacent spaces without being filtered through a central system. Air may not be transferred to or from corridors, to or from adjacent spaces, except as permitted in the applicable edition of the National Fire Protection Association 101 *Life Safety Code* which is currently adopted by the Department.

(d) The dietary dry storage and kitchenware washing rooms may use direct air from the kitchen without being filtered through a central system.

(e) The ventilation rates indicated in subsection (a) are minimum mandatory rates for the area listed and may not be construed as precluding the use of higher rates. For areas not listed, such as dining rooms, lounge and recreation rooms, solaria, and the like, mechanical ventilation rates are optional, but where mechanical ventilation is provided, the supply air shall be obtained from the outdoors through individual room units or from central systems. The unlisted room areas, if ventilated, shall contain an equal pressure relationship.

(f) Where mechanical ventilation is not mandatory or provided, the areas may be ventilated by outside windows that can be easily opened and closed.

(g) Outdoor air intakes may be no less than 25 feet from waste air discharges, such as discharge from ventilation systems, combustion stacks, plumbing vents, vehicle exhaust and the like. The bottom of outdoor air intakes serving central systems and kitchens may not be less than 3 feet above the finished grade or roof level.

(h) Ventilation air openings which are located near floors shall be installed not less than 3 inches above the finished floor.

(i) Air quantities in cubic feet per minute shall be indicated on the drawings for room supply, return and exhaust ventilation openings.

**§ 205.67. Electric requirements for existing and new construction.**

(a) Artificial lighting shall be restricted to electric lighting.

(b) Spaces occupied by people, machinery and equipment within buildings shall have electric lighting which is operational at all times.

(c) Electric lights satisfactory for residents' activities shall be available.

(d) Electric lights in rooms used by residents shall be placed or shaded to prevent direct glare to the eyes of residents.

(e) Night lights shall be provided in bedrooms, stairways, corridors, bathrooms and toilet rooms used by residents.

(f) Arrangements to transfer lighting from overhead fixtures to night light fixtures in stairways and corridors shall be designed so that switches can only select between two sets of fixtures and cannot extinguish both sets at the same time.

(g) In addition to night lights, residents' bedrooms shall have general lighting. The light emitting surfaces of the night light may not be in direct view of a resident in a normal in-bed position.

(h) A reading light shall be provided for each resident.

(i) In each resident room there shall be grounding type receptacles as follows: one duplex receptacle on each side of the head of each bed except for parallel adjacent beds. Only one duplex receptacle is required between beds plus sufficient duplex receptacles to supply portable lights, television and motorized beds, if used, and one duplex receptacle on another wall.

(j) A nurse's calling station—signal originating device—with cable with push button housing attached or other system approved by the Department shall be provided at each resident bed location so that it is accessible to the resident. Two cables and buttons serving adjacent beds may be served by one station. An emergency calling station within reach of the resident shall be provided at each bathing fixture and toilet unless a single bell can be reached by the resident from both the bathing fixture and the toilet. Cable and push button housing requirement will apply to those facilities constructed after July 1, 1987.

(k) Calls shall register by a signal receiving and indicating device at the nurses' station, and shall activate a visible signal in the corridor at the resident's door. In multicorridor nursing units, additional visible signal indicators shall be installed at corridor intersections.

**§ 205.68. Special electrical requirements for new construction.**

(a) Electrical systems and equipment shall comply with the latest edition of the *National Electrical Code, NFPA 70*. If local or State codes are more stringent, the more stringent requirements apply.

(b) Materials comprising the electrical systems shall be listed as complying with applicable standards of the Underwriters' Laboratories, Inc., or other similarly established standards.

(c) Minimum lighting levels for long-term care nursing facilities shall conform with the following:

| *Area* | *Footcandles* |
|---|---|
| Corridors and interior ramps | 20 |
| Stairways other than exits | 30 |
| Exit stairways and landings | 5 on floor |
| Doorways | 10 |
| Administrative and lobby areas, day | 50 |
| Administrative and lobby areas, night | 20 |
| Chapel or quiet area | 30 |
| Physical therapy | 20 |
| Occupational therapy | 30 |
| Worktable, coarse work | 100 |
| Worktable, fine work | 200 |
| Recreation area | 50 |
| Dining area | 30 |
| Resident care unit (or room) general | 10 |

| *Area* | *Footcandles* |
|---|---|
| Resident care room, reading | 30 |
| Nurses' station, general, day | 50 |
| Nurses' station, general, night | 20 |
| Nurses' desk, for charts and records | 70 |
| Nurses' medicine cabinet | 100 |
| Utility room, general | 20 |
| Utility room, work counter | 50 |
| Pharmacy area, general | 30 |
| Pharmacy, compounding and dispensing areas | 100 |
| Janitor's closet | 15 |
| Toilet and bathing facilities | 30 |
| Barber and beautician areas | 50 |

(d) The applicable standards for lighting levels are those established by the current edition of the Illuminating Engineering Society of North America (IES) Lighting Handbook.

### FURNISHINGS, EQUIPMENT AND SUPPLIES

**§ 205.71. Bed and furnishings.**

A bed shall be equipped with a firm supporting mattress which is equal to the size of the frame and provides for the comfort and safety of the resident.

**§ 205.72. Furniture.**

A resident shall be provided with a drawer or cabinet in the resident's room that can be locked.

**§ 205.73. (Reserved).**

**§ 205.74. Linen.**

The facility shall have available at all times a quantity of linens essential for proper care and comfort of patients.

### SUPPLIES

**§ 205.75. Supplies.**

Adequate supplies shall be available at all times to meet the residents' needs.

## CHAPTER 207. HOUSEKEEPING AND MAINTENANCE STANDARDS FOR LONG TERM CARE NURSING FACILITIES

#### HOUSEKEEPING AND MAINTENANCE

Sec.
207.1. (Reserved).
207.2. Administrator's responsibility.
207.3. (Reserved).
207.4. Ice containers and storage.
207.5. (Reserved).

### HOUSEKEEPING AND MAINTENANCE

**§ 207.1. (Reserved).**

**§ 207.2. Administrator's responsibility.**

(a) The administrator shall be responsible for satisfactory housekeeping and maintenance of the buildings and grounds.

(b) Nursing personnel may not be assigned housekeeping duties that are normally assigned to housekeeping personnel.

**§ 207.3. (Reserved).**

**§ 207.4. Ice containers and storage.**

Ice storage containers shall be kept clean, and ice shall be handled in a sanitary manner to prevent contamination.

**§ 207.5. (Reserved).**

## CHAPTER 209. FIRE PROTECTION AND SAFETY PROGRAMS FOR LONG TERM CARE NURSING FACILITIES

#### FIRE PROTECTION AND SAFETY

Sec.
209.1. Fire department service.
209.2. (Reserved).
209.3. Smoking.
209.4. (Reserved).
209.5. (Reserved).
209.6. (Reserved).
209.7. Disaster preparedness.
209.8. Fire drills.

### FIRE PROTECTION AND SAFETY

**§ 209.1. Fire department service.**

The telephone number of the emergency services serving the facility shall be posted by the telephones in each nursing station, office and appropriate place within the facility.

**§ 209.2. (Reserved).**

**§ 209.3. Smoking.**

(a) Policies regarding smoking shall be adopted. The policies shall include provisions for the protection of the rights of the nonsmoking residents. The smoking policies shall be posted in a conspicuous place and in a legible format so that they may be easily read by residents, visitors and staff.

(b) Proper safeguards shall be taken against the fire hazards involved in smoking.

(c) Adequate supervision while smoking shall be provided for those residents who require it.

(d) Smoking by residents in bed is prohibited unless the resident is under direct observation.

(e) Smoking is prohibited in a room, ward or compartment where flammable liquids, combustible gases or oxygen is used or stored, and in other hazardous locations. The areas shall be posted with "NO SMOKING" signs.

(f) Ash trays of noncombustible material and safe design shall be provided in areas where smoking is permitted.

(g) Noncombustible containers with self-closing covers shall be provided in areas where smoking is permitted.

**§ 209.4. (Reserved).**

**§ 209.5. (Reserved).**

**§ 209.6. (Reserved).**

**§ 209.7. Disaster preparedness.**

(a) The facility shall have a comprehensive written disaster plan which shall be developed and maintained with the assistance of qualified fire, safety and other appropriate experts. It shall include procedures for prompt transfer of casualties and records, instructions regarding the location and use of alarm systems and signals and fire fighting equipment, information regarding methods of containing fire, procedures for notification of appropriate persons and specifications of evacuation routes and procedures. The written plan shall be made available to and reviewed with personnel, and it shall be available at each nursing station and in each department. The plan shall be reviewed periodically to determine its effectiveness.

(b) A diagram of each floor showing corridors, line of travel, exit doors and location of the fire extinguishers and pull signals shall be posted on each floor in view of residents and personnel.

(c) All personnel shall be instructed in the operation of the various types of fire extinguishers used in the facility.

**§ 209.8. Fire drills.**

(a) Fire drills shall be held monthly. Fire drills shall be held at least four times per year per shift at unspecified hours of the day and night.

(b) A written report shall be maintained of each fire drill which includes date, time required for evacuation or relocation, number of residents evacuated or moved to another location and number of personnel participating in a fire drill.

## CHAPTER 211. PROGRAM STANDARDS FOR LONG TERM CARE NURSING FACILITIES

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**§ 211.1. Reportable diseases.**

(a) When a resident develops a reportable disease, the administrator shall report the information to the appropriate health agencies and appropriate Division of Nursing Care Facilities field office. Reportable diseases and conditions are:

Acquired Immune Deficiency Syndrome

Amebiasis

Animal Bites

Anthrax

Botulism

Brucellosis

Campylobacteriosis

Chlamydia Trachomatous Infections

Cholera

Diptheria

Encephalitis

Food Poisoning

Giardiasis

Gonococcal Infections

Guillian-Barre Syndrome

Haemophilus influenzae type b disease

Hepatitis, Viral, including Type A and Type B

Hepatitis, non-A and non-B

Histoplasmosis

Kawasaki disease

Legionnaires' disease

Leptospirosis

Lyme Disease

Lymphogranuloma venereum

Malaria

Measles

Meningitis-all types

Meningococcal Disease

Mumps

Pertussis (whooping cough)

Plague

Poliomyelitis

Psittacosis (ornithosis)

Rabies

Reye's syndrome

Rickettsial diseases, including Rocky Mountain Spotted Fever

Rubella (German measles) and congenital rubella syndrome

Salmonellosis

Shigellosis

Syphilis, all stages

Tetanus

Toxic Shock Syndrome

Toxoplasmosis

Trichinosis

Tuberculosis, all forms

Tularemia

Typhoid

Yellow Fever

(b) Cases of scabies and lice shall be reported to the appropriate Division of Nursing Care Facilities field office.

(c) Significant nosocomial outbreaks, as determined by the facility's medical director, of Methicillin Resistant Staphylococcus Aureus (MRSA), Vancomycin-Resistant Staphylococcus Aureus (VRSA), Vancomycin-Resistant Enterococci (VRE), and Vancomycin-Resistant Staphylococcus Epidermidis (VRSE) shall be reported to the appropriate Division of Nursing Care Facilities field office.

**§ 211.2. Physician services.**

(a) The attending physician shall be responsible for the medical evaluation of the resident and shall prescribe a planned regimen of total resident care.

(b) The facility shall have available, prior to or at the time of admission, resident information which includes current medical findings, diagnoses and orders from a physician for immediate care of the resident. The resident's initial medical assessment shall be conducted no later than 14 days after admission and include a summary of the prior treatment as well as the resident's rehabilitation potential.

(c) A facility shall have a medical director who is licensed as a physician in this Commonwealth and who is responsible for the overall coordination of the medical

care in the facility to ensure the adequacy and appropriateness of the medical services provided to the residents. The medical director may serve on a full- or part-time basis depending on the needs of the residents and the facility and may be designated for single or multiple facilities. There shall be a written agreement between the physician and the facility.

(d) The medical director's responsibilities shall include at least the following:

(1) Review of incidents and accidents that occur on the premises and addressing the health and safety hazards of the facility. The administrator shall be given appropriate information from the medical director to help insure a safe and sanitary environment for residents and personnel.

(2) Development of written policies which are approved by the governing body that delineate the responsibilities of attending physicians.

**§ 211.3. Oral and telephone orders.**

(a) A physician's oral and telephone orders shall be given to a registered nurse, physician or other individual authorized by appropriate statutes and the State Boards in the Bureau of Professional and Occupational Affairs and shall immediately be recorded on the resident's clinical record by the person receiving the order. The entry shall be signed and dated by the person receiving the order. Written orders may be by fax.

(b) A physician's oral and telephone orders for care and treatments, shall be dated and countersigned with the original signature of the physician within 7 days of receipt of the order. If the physician is not the attending physician, he shall be authorized and the facility so informed by the attending physician and shall be knowledgeable about the resident's condition.

(c) A physician's telephone and oral orders for medications shall be dated and countersigned by the prescribing practitioner within 48 hours. Oral orders for Schedule II drugs are permitted only in a bona fide emergency.

(d) Oral orders for medication or treatment shall be accepted only under circumstances where it is impractical for the orders to be given in a written manner by the responsible practitioner. An initial written order as well as a countersignature may be received by a fax which includes the practitioner's signature.

(e) The facility shall establish policies identifying the types of situations for which oral orders may be accepted and the appropriate protocols for the taking and transcribing of oral orders in these situations, which shall include:

(1) Identification of all treatments or medications which may not be prescribed or dispensed by way of an oral order, but which instead require written orders.

(2) A requirement that all oral orders be stated clearly, repeated by the issuing practitioner, and be read back in their entirety by personnel authorized to take the oral order.

(3) Identification of all personnel authorized to take and transcribe oral orders.

(4) The policy on fax transmissions.

**§ 211.4. Procedure in event of death.**

(a) Written postmortem procedures shall be available at each nursing station.

(b) Documentation shall be on the resident's clinical record that the next of kin, guardian or responsible party has been notified of the resident's death. The name of the notified party shall be written on the resident's clinical record.

**§ 211.5. Clinical records.**

(a) Clinical records shall be available to, but not be limited to, representatives of the Department of Aging Ombudsman Program.

(b) Information contained in the resident's record shall be privileged and confidential. Written consent of the resident, or of a designated responsible agent acting on the resident's behalf, is required for release of information. Written consent is not necessary for authorized representatives of the State and Federal government during the conduct of their official duties.

(c) Records shall be retained for a minimum of 7 years following a resident's discharge or death.

(d) Records of discharged residents shall be completed within 30 days of discharge. Clinical information pertaining to a resident's stay shall be centralized in the resident's record.

(e) When a facility closes, resident clinical records may be transferred with the resident if the resident is transferred to another health care facility. Otherwise, the owners of the facility shall make provisions for the safekeeping and confidentiality of clinical records and shall notify the Department of how the records may be obtained.

(f) At a minimum, the resident's clinical record shall include physicians' orders, observation and progress notes, nurses' notes, medical and nursing history and physical examination reports; identification information, admission data, documented evidence of assessment of a resident's needs, establishment of an appropriate treatment plan and plans of care and services provided; hospital diagnoses authentication—discharge summary, report from attending physician or transfer form—diagnostic and therapeutic orders, reports of treatments, clinical findings, medication records and discharge summary including final diagnosis and prognosis or cause of death. The information contained in the record shall be sufficient to justify the diagnosis and treatment, identify the resident and show accurately documented information.

(g) Symptoms and other indications of illness or injury, including the date, time and action taken shall be recorded.

(h) Each professional discipline shall enter the appropriate historical and progress notes in a timely fashion in accordance with the individual needs of a resident.

(i) The facility shall assign overall supervisory responsibility for the clinical record service to a medical records practitioner. Consultative services may be utilized, however, the facility shall employ sufficient personnel competent to carry out the functions of the medical record service.

**§ 211.6. Dietary services.**

(a) Menus shall be planned at least 2 weeks in advance. Records of menus of foods actually served shall be retained for 30 days. When changes in the menu are necessary, substitutions shall provide equal nutritive value.

(b) Sufficient food to meet the nutritional needs of residents shall be prepared as planned for each meal.

There shall be at least 3 days' supply of food available in storage in the facility at all times.

(c) Overall supervisory responsibility for the dietary services shall be assigned to a full-time qualified dietary services supervisor.

(d) If consultant dietary services are used, the consultant's visits shall be at appropriate times and of sufficient duration and frequency to provide continuing liaison with medical and nursing staff, advice to the administrator, resident counseling, guidance to the supervisor and staff of the dietary services, approval of menus, and participation in development or revision of dietary policies and procedures and in planning and conducting inservice education and programs.

(e) A current therapeutic diet manual approved jointly by the dietitian and medical director shall be readily available to attending physicians and nursing and dietetic service personnel.

(f) Dietary personnel shall practice hygienic food handling techniques. An employe shall wear clean outer garments, maintain a high degree of personal cleanliness and conform to hygienic practices while on duty. Employes shall wash their hands thoroughly with soap and water before starting work, after visiting the toilet room and as often as necessary to remove soil and contamination.

**§ 211.7. Physician assistants and certified registered nurse practitioners.**

(a) Physician assistants and certified registered nurse practitioners may be utilized in facilities, in accordance with their training and experience and the requirements in statutes and regulations governing their respective practice.

(b) If the facility utilizes the services of physician assistants or certified registered nurse practitioners, the following apply:

(1) There shall be written policies indicating the manner in which the physician assistants and certified registered nurse practitioners shall be used and the responsibilities of the supervising physician.

(2) There shall be a list posted at each nursing station of the names of the supervising physician and the persons, and titles, whom they supervise.

(3) A copy of the supervising physician's registration from the State Board of Medicine or State Board of Osteopathic Medicine and the physician assistant's or certified registered nurse practitioner's certificate shall be available in the facility.

(4) A notice plainly visible to residents shall be posted in prominent places in the institution explaining the meaning of the terms "physician assistant" and "certified registered nurse practitioner."

(c) Physician assistants' and certified registered nurse practitioners' documentation on the resident's record shall be countersigned by the supervising physician within 7 days with an original signature and date by the licensed physician. This includes progress notes, physical examination reports, treatments, medications and any other notation made by the physician assistant or certified registered nurse practitioner.

(d) Physicians shall countersign and date their verbal orders to physician assistants or certified registered nurse practitioners within 7 days.

(e) This section may not be construed to relieve the individual physician, group of physicians, physician assistant or certified registered nurse practitioner of responsibility imposed by statute or regulation.

**§ 211.8. Use of restraints.**

(a) Restraints may not be used in lieu of staff effort. Locked restraints may not be used.

(b) Restraints may not be used or applied in a manner which causes injury to the resident.

(c) Physical restraints shall be removed at least 10 minutes out of every 2 hours during the normal waking hours to allow the resident an opportunity to move and exercise. Except during the usual sleeping hours, the resident's position shall be changed at least every 2 hours. During sleeping hours, the position shall be changed as indicated by the resident's needs.

(d) A signed, dated, written physician order shall be required for a restraint. This includes the use of chest, waist, wrist, ankle, drug or other form of restraint. The order shall include the type of restraint to be used.

(e) The physician shall document the reason for the initial restraint order and shall review the continued need for the use of the restraint order by evaluating the resident. If the order is to be continued, the order shall be renewed by the physician in accordance with the resident's total program of care.

(f) Every 30 days, or sooner if necessary, the interdisciplinary team shall review and reevaluate the use of all restraints ordered by physicians.

**§ 211.9. Pharmacy services.**

(a) Facility policies shall ensure that:

(1) Facility staff involved in the administration of resident care shall be knowledgeable of the policies and procedures regarding pharmacy services including medication administration.

(2) Only licensed pharmacists shall dispense medications for residents. Licensed physicians may dispense medications to the residents who are in their care.

(b) Medications shall be administered by authorized persons as indicated in § 201.3 (relating to definitions).

(c) Medications and biologicals shall be administered by the same licensed person who prepared the dose for administration and shall be given as soon as possible after the dose is prepared.

(d) Medications shall be administered under the written orders of the attending physician.

(e) Each resident shall have a written physician's order for each medication received. This includes both proprietary and nonproprietary medications.

(f) Residents shall be permitted to purchase prescribed medications from the pharmacy of their choice. If the resident does not use the pharmacy that usually services the facility, the resident is responsible for securing the medications and for assuring that applicable pharmacy regulations and facility policies are met. The facility:

(1) Shall notify the resident or the resident's responsible person, at admission and as necessary throughout the resident's stay in the facility, of the right to purchase medications from a pharmacy of the resident's choice as well as the resident's and pharmacy's responsibility to

comply with the facility's policies and State and Federal laws regarding packaging and labeling requirements.

(2) Shall have procedures for receipt of medications from outside pharmacies including requirements for ensuring accuracy and accountability. Procedures shall include the review of medications for labeling requirements, dosage and instructions for use by licensed individuals who are authorized to administer medications.

(3) Shall ensure that the pharmacist or pharmacy consultant will receive a monthly resident medication profile from the selected pharmacy provider.

(4) Shall have a policy regarding the procurement of medications in urgent situations. Facilities may order a 7-day supply from a contract pharmacy if the resident's selected pharmacy is not able to comply with these provisions.

(g) If over-the-counter drugs are maintained in the facility, they shall bear the original label and shall have the name of the resident on the label of the container. The charge nurse may record the resident's name on the nonprescription label. The use of nonprescription drugs shall be limited by quantity and category according to the needs of the resident. Facility policies shall indicate the procedure for handling and billing of nonprescription drugs.

(h) If a unit of use or multiuse systems are used, applicable statutes shall be met. Unit of use dispensing containers or multiuse cards shall be properly labeled. Individually wrapped doses shall be stored in the original container from which they were dispensed.

(i) At least quarterly, outdated, deteriorated or recalled medications shall be identified and returned to the dispensing pharmacy for disposal in accordance with acceptable professional practices. Written documentation shall be made regarding the disposition of these medications.

(j) Disposition of discontinued and unused medications and medications of discharged or deceased residents shall be handled by facility policy which shall be developed in cooperation with the consultant pharmacist. The method of disposition and quantity of the drugs shall be documented on the respective resident's chart. The disposition procedures shall be done at least quarterly under Commonwealth and Federal statutes.

(k) The oversight of pharmaceutical services shall be the responsibility of the quality assurance committee. Arrangements shall be made for the pharmacist responsible for the adequacy and accuracy of the services to have committee input. The quality assurance committee, with input from the pharmacist, shall develop written policies and procedures for drug therapy, distribution, administration, control, accountability and use.

(l) A facility shall have at least one emergency medication kit. The kit used in the facility shall be governed by the following:

(1) The facility shall have written policies and procedures pertaining to the use, content, storage and refill of the kits.

(2) The quantity and categories of medications and equipment in the kits shall be kept to a minimum and shall be based on the immediate needs of the facility.

(3) The emergency medication kits shall be under the control of a practitioner authorized to dispense or prescribe medications under the Pharmacy Act (63 P. S. §§ 390.1—390.13).

(4) The kits shall be kept readily available to staff and shall have a breakaway lock which shall be replaced after each use.

**§ 211.10. Resident care policies.**

(a) Resident care policies shall be available to admitting physicians, sponsoring agencies, residents and the public, shall reflect an awareness of, and provision for, meeting the total medical and psychosocial needs of residents. The needs include admission, transfer and discharge planning.

(b) The policies shall be reviewed at least annually and updated as necessary.

(c) The policies shall be designed and implemented to ensure that each resident receives treatments, medications, diets and rehabilitative nursing care as prescribed.

(d) The policies shall be designed and implemented to ensure that the resident receives proper care to prevent pressure sores and deformities; that the resident is kept comfortable, clean and well-groomed; that the resident is protected from accident, injury and infection; and that the resident is encouraged, assisted and trained in self-care and group activities.

**§ 211.11. Resident care plan.**

(a) The facility shall designate an individual to be responsible for the coordination and implementation of a written resident care plan. This responsibility shall be included as part of the individual's job description.

(b) The individual responsible for the coordination and implementation of the resident care plan shall be part of the interdisciplinary team.

(c) A registered nurse shall be responsible for developing the nursing assessment portion of the resident care plan.

(d) The resident care plan shall be available for use by personnel caring for the resident.

(e) The resident, when able, shall participate in the development and review of the care plan.

**§ 211.12. Nursing services.**

(a) The facility shall provide services by sufficient numbers of personnel on a 24-hour basis to provide nursing care to meet the needs of all residents.

(b) There shall be a full-time director of nursing services who shall be a qualified licensed registered nurse.

(c) The director of nursing services shall have, in writing, administrative authority, responsibility and accountability for the functions and activities of the nursing services staff, and shall serve only one facility in this capacity.

(d) The director of nursing services shall be responsible for:

(1) Standards of accepted nursing practice.

(2) Nursing policy and procedure manuals.

(3) Methods for coordination of nursing services with other resident services.

(4) Recommendations for the number and levels of nursing personnel to be employed.

(5) General supervision, guidance and assistance for a resident in implementing the resident's personal health program to assure that preventive measures, treatments, medications, diet and other health services prescribed are properly carried out and recorded.

(e) The facility shall designate a registered nurse who is responsible for overseeing total nursing activities within the facility on each tour of duty each day of the week.

(f) In addition to the director of nursing services, the following daily professional staff shall be available.

(1) The following minimum nursing staff ratios are required:

| *Census* | *Day* | *Evening* | *Night* |
|---|---|---|---|
| 59 and under | 1 RN | 1 RN | 1 RN or 1 LPN |
| 60/150 | 1 RN | 1 RN | 1 RN |
| 151/250 | 1 RN and 1 LPN | 1 RN and 1 LPN | 1 RN and 1 LPN |
| 251/500 | 2 RNs | 2 RNs | 2 RNs |
| 501/1,000 | 4 RNs | 3 RNs | 3 RNs |
| 1,001/Upward | 8 RNs | 6 RNs | 6 RNs |

(2) When the facility designates an LPN as a nurse who is responsible for overseeing total nursing activities within the facility on the night tour of duty in facilities with a census of 59 or under, a registered nurse shall be on call and located within a 30-minute drive of the facility.

(g) There shall be at least one nursing staff employe on duty per 20 residents.

(h) At least two nursing service personnel shall be on duty.

(i) A minimum number of general nursing care hours shall be provided for each 24-hour period. The total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 2.7 hours of direct resident care for each resident.

(j) Nursing personnel shall be provided on each resident floor.

(k) Weekly time schedules shall be maintained and shall indicate the number and classification of nursing personnel, including relief personnel, who worked on each tour of duty on each nursing unit.

(l) The Department may require an increase in the number of nursing personnel from the minimum requirements if specific situations in the facility—including, but not limited to, the physical or mental condition of residents, quality of nursing care administered, the location of residents, the location of the nursing station and location of the facility—indicate the departures as necessary for the welfare, health and safety of the residents.

**§ 211.13. (Reserved).**

**§ 211.14. (Reserved).**

**§ 211.15. Dental services.**

(a) The facility shall assist residents in obtaining routine and 24-hour emergency dental care.

(b) The facility shall make provisions to assure that resident dentures are retained by the resident. Dentures shall be marked for each resident.

**§ 211.16. Social services.**

(a) The facility shall provide social services designed to promote preservation of the patient's physical and mental health and to prevent the occurrence or progression of personal and social problems. Facilities with a resident census of more than 120 residents shall employ a qualified social worker on a full-time basis.

(b) In facilities with 120 beds or less that do not employ a full-time social worker, social work consultation by a qualified social worker shall be provided and documented on a regular basis.

**§ 211.17. Pet therapy.**

If pet therapy is utilized, the following standards apply:

(1) Animals are not permitted in the kitchen or other food service areas, dining rooms when meals are being served, utility rooms and rooms of residents who do not want animals in their rooms.

(2) Careful selection of types of animals shall be made so they are not harmful or annoying to residents.

(3) The number and types of pets shall be restricted according to the layout of the building, type of residents, staff and animals.

(4) Pets shall be carefully selected to meet the needs of the residents involved in the pet therapy program.

(5) The facility shall have written procedures established which will address the physical and health needs of the animals. Rabies shots shall be given to animals who are potential victims of the disease. Care of the pets may not be imposed on anyone who does not wish to be involved.

(6) Pets and places where they reside shall be kept clean and sanitary.

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