

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

**CHAPTER 1200-8-6  
STANDARDS FOR NURSING HOMES**

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**1200-8-6-.01 DEFINITIONS.**

- (1) Administrator. A person currently licensed as such by the Tennessee Board of Examiners for Nursing Home Administrators.
- (2) Advance Directive. A written statement such as a living will, a durable power of attorney for health care or a do not resuscitate order relating to the provision of health care when the individual is incapacitated.
- (3) Board. The Tennessee Board for Licensing Health Care Facilities.
- (4) Cardiopulmonary Resuscitation (CPR). The administering of any means or device to restore or support cardiopulmonary functions in a resident, whether by mechanical devices, chest compressions, mouth-to-mouth resuscitation, cardiac massage, tracheal intubation, manual or mechanical ventilations or respirations, defibrillation, the administration of drugs and/or chemical agents intended to restore cardiac and/or respiratory functions in a resident where cardiac or respiratory arrest has occurred or is believed to be imminent.
- (5) Certified Nurse Aide or Certified Nursing Assistant. An individual who has successfully completed an approved nursing assistant training program and is registered with the department.
- (6) Commissioner. The Commissioner of the Tennessee Department of Health or his or her authorized representative.
- (7) Competent. Having decision-making capacity.
- (8) Corrective Action Plan/Report. A report filed with the department by the facility after reporting an unusual event. The report must consist of the following:
  - (a) the action(s) implemented to prevent the reoccurrence of the unusual event,
  - (b) the time frames for the action(s) to be implemented,
  - (c) the person(s) designated to implement and monitor the action(s), and
  - (d) the strategies for the measurements of effectiveness to be established.

(Rule 1200-8-6-.01, continued)

- (9) Decision-making capacity. Decision-making capacity is shown by the fact that the person is able to understand the proposed procedure, its risks and benefits, and the available alternative procedures.
- (10) Department. The Tennessee Department of Health.
- (11) Dietitian. A person currently licensed as such by the Tennessee Board of Dietitian/Nutritionist Examiners. Persons exempt from licensure shall be registered with the American Dietetics Association pursuant to T.C.A. § 63-25-104.
- (12) Director of Nursing (DON). A Registered Nurse employed full time in a nursing home who satisfies the responsibilities set forth in this chapter.
- (13) Do Not Resuscitate (DNR) Order. An order entered by the resident's treating physician in the resident's medical record which states that in the event the resident suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should not be attempted. The order may contain limiting language to allow only certain types of cardiopulmonary resuscitation to the exclusion of other types of cardiopulmonary resuscitation.
- (14) Hazardous Waste. Materials whose handling, use, storage, and disposal are governed by local, state or federal regulations.
- (15) Health care decision. A decision made by an individual or the individual's health care decision-maker, regarding the individual's health care including but not limited to:
  - (a) the selection and discharge of health-care providers and institutions;
  - (b) approval or disapproval of diagnostic tests, surgical procedures, programs of administration of medication, and orders not to resuscitate;
  - (c) directions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care; and
  - (d) transfer to other health care facilities.
- (16) Health Care Decision-maker. In the case of an incompetent resident, or a resident who lacks decision-making capacity, the resident's health care decision-maker is one of the following: the resident's health care agent as specified in an advance directive, the resident's court-appointed legal guardian or conservator with health care decision-making authority, or the resident's surrogate as determined pursuant to Rule 1200-8-6-.13 or T.C.A. §33-3-220.
- (17) Hospital. Any institution, place, building or agency represented and held out to the general public as ready, willing and able to furnish care, accommodations, facilities and equipment for the use, in connection with the services of a physician or dentist, of one (1) or more nonrelated persons who may be suffering from deformity, injury or disease or from any other condition for which nursing, medical or surgical services would be appropriate for care, diagnosis or treatment.
- (18) Hospitalization. The reception and care of any person for a continuous period longer than twenty-four (24) hours, for the purpose of giving advice, diagnosis, nursing service or treatment bearing on the physical health of such person, and maternity care involving labor and delivery for any period of time.
- (19) Incompetent. A resident who has been adjudicated incompetent by a court of competent jurisdiction and has not been restored to legal capacity.
- (20) Infectious Waste. Solid or liquid wastes which contain pathogens with sufficient virulence and quantity such that exposure to the waste by a susceptible host could result in an infectious disease.

(Rule 1200-8-6-.01, continued)

- (21) **Involuntary Transfer.** The movement of a resident between nursing homes, without the consent of the resident, the resident's legal guardian, next of kin or representative.
- (22) **Lacks Decision-Making Capacity.** Lacks Decision-Making Capacity means the factual demonstration by the attending physician and the medical director, or the attending physician and another physician that an individual is unable to understand:
  - (a) A proposed health care procedure(s), treatment(s), intervention(s), or interaction(s);
  - (b) The risks and benefits of such procedure(s), treatment(s), intervention(s) or interaction(s); and
  - (c) The risks and benefits of any available alternative(s) to the proposed procedure(s), treatment(s), intervention(s) or interaction(s).
- (23) **Legal Guardian.** Any person authorized to act for the resident pursuant to any provision of T.C.A. §§34-5-102(4) or 34-11-101, or any successor statute thereto.
- (24) **Licensed Practical Nurse.** A person currently licensed as such by the Tennessee Board of Nursing.
- (25) **Licensee.** The person or entity to whom the license is issued. The licensee is held responsible for compliance with all rules and regulations.
- (26) **Life Threatening Or Serious Injury.** Injury requiring the patient to undergo significant additional diagnostic or treatment measures.
- (27) **Medical Director.** A licensed physician employed by the nursing home to be responsible for medical care in the facility.
- (28) **Medical Emergency.** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the resident's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.
- (29) **Medical Record.** Medical histories, records, reports, summaries, diagnoses, prognoses, records of treatment and medication ordered and given, entries, x-rays, radiology interpretations and other written, electronic, or graphic data prepared, kept, made or maintained in a facility that pertains to confinement or services rendered to residents.
- (30) **Medically Futile Treatment.** Resuscitation efforts that cannot be expected either to restore cardiac or respiratory function to the resident or to achieve the expressed goals of the informed resident. In the case of the incompetent resident, the resident's representative expresses the goals of the resident.
- (31) **NFPA.** The National Fire Protection Association.
- (32) **Nurse Aide or Nursing Assistant Training Program.** A specialized program approved by the Department to provide classroom instruction and supervised clinical experience for individuals who wish to be employed as Nurse Aides or Nursing Assistants.
- (33) **Nursing Personnel.** Licensed nurses and certified nurse aides who provide nursing care.
- (34) **Occupational Therapist.** A person currently licensed as such by the Tennessee Board of Occupational and Physical Therapy Examiners.

(Rule 1200-8-6-.01, continued)

- (35) Patient Abuse. Patient neglect, intentional infliction of pain, injury, or mental anguish. Patient abuse includes the deprivation of services by a caretaker which are necessary to maintain the health and welfare of a patient or resident; however, the withholding of authorization for or provision of medical care to any terminally ill person who has executed an irrevocable living will in accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of such living will shall not be deemed "patient abuse" for purposes of these rules.
- (36) Pharmacist. A person currently licensed as such by the Tennessee Board of Pharmacy.
- (37) Physical Therapist. A person currently licensed as such by the Tennessee Board of Occupational and Physical Therapy Examiners.
- (38) Physician. A person currently licensed as such by the Tennessee Board of Medical Examiners or by the Tennessee Board of Osteopathic Examination.
- (39) Podiatrist. A person currently licensed as such by the Tennessee Board of Registration in Podiatry.
- (40) Program Coordinator. A registered nurse who possesses a minimum of two years nursing experience with at least one year in long term care and is responsible for ensuring that the requirements of the Nurse Aide Training Program are met.
- (41) Registered Nurse. A person currently licensed as such by the Tennessee Board of Nursing.
- (42) Resident/Patient. Includes but is not limited to any person who is suffering from an illness or injury and who is in need of nursing care.
- (43) Secured Unit. A facility or distinct part of a facility where residents are intentionally denied egress by any means.
- (44) Shall or Must. Compliance is mandatory.
- (45) Social Worker. In a facility with more than 120 beds a qualified social worker is an individual with:
  - (a) A bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and,
  - (b) One year of supervised social work experience in a health care setting working directly with individuals.
- (46) Speech Therapist. A person currently licensed as such by the Tennessee Board of Communication Disorders and Sciences.
- (47) Student. A person currently enrolled in a course of study that is approved by the appropriate licensing board.
- (48) Survey. An on-site examination by the department to determine the quality of care and/or services provided.
- (49) Transfer. The movement of a resident between nursing homes at the direction of a physician or other qualified medical personnel when a physician is not readily available. The term does not include movement of a resident who leaves the facility against medical advice. The term does not apply to the commitment and movement of mentally ill and mentally retarded persons, the discharge or release of a resident no longer in need of nursing home care, or a nursing home's refusal, after an appropriate

(Rule 1200-8-6-.01, continued)

medical screening, to render any medical care on the grounds that the person does not have a medical need for nursing home care.

- (50) **Treating Physician.** The physician selected by or assigned to the resident and who has the primary responsibility for the treatment and care of the resident. Where more than one physician shares such responsibility, any such physician may be deemed to be the “treating physician.”
- (51) **Unusual Event.** The abuse of a patient or an unexpected occurrence or accident that results in death, life threatening or serious injury to a patient that is not related to a natural course of the patient’s illness or underlying condition.
- (52) **Unusual Event Report.** A report form designated by the department to be used for reporting an unusual event.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, and 68-11-213. **Administrative History:** Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed April 10, 2000; effective June 24, 2000. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed April 28, 2003; effective July 12, 2003.

#### **1200-8-6-.02 LICENSING PROCEDURES.**

- (1) No person, partnership, association, corporation, or any state, county or local governmental unit, or any division, department, board or agency thereof, shall establish, conduct, operate, or maintain in the State of Tennessee any nursing home without having a license. A license shall be issued only to the applicant named and only for the premises listed in the application for licensure. Satellite facilities shall be prohibited. Licenses are not transferable or assignable and shall expire annually on June 30th. The license shall be conspicuously posted in the nursing home.
- (2) In order to make application for a license:
  - (a) The applicant shall submit an application on a form provided by the department along with a copy of the Certificate of Need (CON) issued by the Tennessee Health Facilities Commission. Any condition placed on the CON will also be placed on the license.
  - (b) Each applicant for a license shall pay an annual license fee based on the number of nursing home beds. The fee must be submitted with the application and is not refundable.
  - (c) The issuance of an application form is in no way a guarantee that the completed application will be accepted or that a license will be issued by the department. Residents shall not be admitted to the nursing home until a license has been issued. Applicants shall not hold themselves out to the public as being a nursing home until the license has been issued. A license shall not be issued until the facility is in substantial compliance with these rules, including submission of all information required by T.C.A. §68-11-206(1) or as later amended, and all information required by the Commissioner.
  - (d) The applicant shall not use subterfuge or other evasive means to obtain a license, such as filing for a license through a second party when an individual has been denied a license or has had a license disciplined or has attempted to avoid inspection and review process.
- (3) A proposed change of ownership, including a change in a controlling interest, must be reported to the department a minimum of thirty (30) days prior to the change. A new application and fee must be received by the department before the license may be issued.

(Rule 1200-8-6-.02, continued)

- (a) For the purpose of licensing, the licensee of a nursing home has the ultimate responsibility for the operation of the facility, including the final authority to make or control operational decisions and legal responsibility for the business management. A change of ownership occurs whenever this ultimate legal authority for the responsibility of the nursing home's operation is transferred.
  - (b) A change of ownership occurs whenever there is a change in the legal structure by which the nursing home is owned and operated.
  - (c) Transactions constituting a change of ownership include, but are not limited to, the following:
    - 1. Transfer of the facility's legal title;
    - 2. Lease of the facility's operations;
    - 3. Dissolution of any partnership that owns, or owns a controlling interest in, the facility.
    - 4. One partnership is replaced by another through the removal, addition or substitution of a partner;
    - 5. Removal of the general partner or general partners, if the facility is owned by a limited partnership;
    - 6. Merger of a facility owner (a corporation) into another corporation where, after the merger, the owner's shares of capital stock are canceled;
    - 7. The consolidation of a corporate facility owner with one or more corporations; or,
    - 8. Transfers between levels of government.
  - (d) Transactions which do not constitute a change of ownership include, but are not limited to, the following:
    - 1. Changes in the membership of a corporate board of directors or board of trustees;
    - 2. Two (2) or more corporations merge and the originally-licensed corporation survives;
    - 3. Changes in the membership of a non-profit corporation;
    - 4. Transfers between departments of the same level of government; or,
    - 5. Corporate stock transfers or sales, even when a controlling interest.
  - (e) Management agreements are generally not changes of ownership if the owner continues to retain ultimate authority for the operation of the facility. However, if the ultimate authority is surrendered and transferred from the owner to a new manager, then a change of ownership has occurred.
  - (f) Sale/lease-back agreements shall not be treated as changes in ownership if the lease involves the facility's entire real and personal property and if the identity of the lessee, who shall continue the operation, retains the same legal form as the former owner.
- (4) Each nursing home, except those operated by the U.S. Government or the State of Tennessee, making application for license under this chapter, shall pay annually to the department a fee based on the number of nursing home beds, as follows:

(Rule 1200-8-6-.02, continued)

(a)	Less than 25 beds	\$ 600.00
(b)	25 to 49 beds, inclusive	\$ 800.00
(c)	50 to 74 beds, inclusive	\$ 950.00
(d)	75 to 99 beds, inclusive	\$ 1,100.00
(e)	100 to 124 beds, inclusive	\$ 1,250.00
(f)	125 to 149 beds, inclusive	\$ 1,400.00
(g)	150 to 174 beds, inclusive	\$ 1,550.00
(h)	175 to 199 beds, inclusive	\$ 1,700.00

For nursing homes of two hundred (200) beds or more the fee shall be one thousand seven hundred dollars (\$1,700.00) plus one hundred fifty dollars (\$150.00) for each twenty-five (25) beds or fraction thereof in excess of one hundred ninety-nine (199) beds. The fee shall be submitted with the application or renewal and is not refundable. When additional beds are licensed, the licensing procedures for new facilities must be followed and the difference between the fee previously paid and the fee for the new bed capacity, if any, must be paid.

- (5) To be eligible for a license or renewal of a license, each nursing home shall be periodically inspected for compliance with these rules. If deficiencies are identified, an acceptable plan of correction must be submitted to the department.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216.  
**Administrative History:** Original rules filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Amendment filed March 13, 1986; effective April 12, 1986. Amendment filed December 30, 1986; effective February 13, 1987. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed November 19, 2003; effective February 2, 2004.

### 1200-8-6-.03 DISCIPLINARY PROCEDURES.

- (1) The board may suspend or revoke a license for:
- (a) Violation of federal statutes or rules;
  - (b) Violation of state statutes or the rules as set forth in this chapter;
  - (c) Permitting, aiding or abetting the commission of any illegal act in the nursing home;
  - (d) Conduct or practice found by the board to be detrimental to the health, safety, or welfare of the residents of the nursing home; and,
  - (e) Failure to renew the license.
- (2) The board may consider all factors which it deems relevant, including but not limited to the following, when determining sanctions:
- (a) The degree of sanctions necessary to ensure immediate and continued compliance;

(Rule 1200-8-6-.03, continued)

- (b) The character and degree of impact of the violation on the health, safety and welfare of the residents in the facility;
  - (c) The conduct of the facility in taking all feasible steps or procedures necessary or appropriate to comply or correct the violation; and,
  - (d) Any prior violations by the facility of statutes, rules or orders of the commissioner or the board.
- (3) When a nursing home is found by the department to have committed a violation of this chapter, the department will issue to the facility a statement of deficiencies. Within ten (10) days of the receipt of the statement of deficiencies, the facility must return a plan of correction indicating the following:
- (a) How the deficiency will be corrected;
  - (b) The date upon which each deficiency will be corrected;
  - (c) What measures or systemic changes will be put in place to ensure that the deficient practice does not recur; and,
  - (d) How the corrective action will be monitored to ensure that the deficient practice does not recur.
- (4) Either failure to submit a plan of correction in a timely manner or a finding by the department that the plan of correction is unacceptable shall subject the nursing home's license to possible disciplinary action.
- (5) Whenever the commissioner exercises the authority to suspend the admission of any new resident(s) to the nursing home because of detrimental conditions, as provided by T.C.A. § 68-11-207(b), the nursing home shall post a copy of the commissioner's order upon the public entrance doors of the facility and prominently display it there for so long as it remains effective. During the suspension of admissions, the nursing home shall inform any person who inquires about the admission of a new resident of the provisions of the order and make a copy of the order available.
- (6) Any licensee or applicant for a license, aggrieved by a decision or action of the department or board, pursuant to this chapter, may request a hearing before the board. The proceedings and judicial review of the board's decision shall be in accordance with the Uniform Administrative Procedures Act, T.C.A. §§ 4-5-101, et seq.

**Authority:** T.C.A. §§4-5-202, 68-11-202, 68-11-204, and 68-11-206 through 68-11-209. **Administrative History:** Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Amendment filed March 13, 1986; effective April 12, 1986. Amendment filed December 30, 1986; effective February 13, 1987. Repeal and new rule filed January 31, 2000; effective April 15, 2000.

#### **1200-8-6-.04 ADMINISTRATION.**

- (1) The nursing home shall have a full-time (working at least 32 hours per week) administrator licensed in Tennessee, who shall not function as the director of nursing. Any change of administrators shall be reported in writing to the department within fifteen (15) days. The administrator shall designate in writing an individual to act in his/her absence in order to provide the nursing home with administrative direction at all times. The administrator shall assure the provision of appropriate fiscal resources and personnel required to meet the needs of the residents.
- (2) The hospital administrator may serve as the administrator of a hospital-based nursing home provided that he/she is a Tennessee licensed nursing home administrator, the facilities are located on the same campus, and the surveys do not reflect substandard care.

(Rule 1200-8-6-.04, continued)

- (3) Any agreement to manage a nursing home must be reported in writing to the department within fifteen (15) days of its implementation.
- (4) Upon the unexpected loss of the facility administrator, the facility shall proceed according to the following provisions:
  - (a) The term “unexpected loss” means the absence of a nursing home administrator due to serious illness or incapacity, unplanned hospitalization, death, resignation with less than thirty (30) days notice or unplanned termination.
  - (b) The facility must notify the department within twenty-four (24) hours after notice of the unexpected loss of the administrator. Notification to the department shall identify an individual to be responsible for administration of the facility for the immediate future not to exceed thirty (30) days. This responsible individual need not be licensed as an administrator and may be the facility’s director of nursing.
  - (c) Within seven (7) days of notice of the unexpected loss, the facility must request a waiver of the appropriate regulations from the board.
  - (d) On or before the expiration of thirty (30) days after notice of the unexpected loss, the facility shall appoint a temporary administrator to serve until either a permanent administrator is employed or the request for a waiver is considered by the board, whichever occurs first. The temporary administrator shall be any of the following:
    1. A full-time administrator licensed in Tennessee or any other state;
    2. One (1) or more part-time administrators licensed in Tennessee. Part-time shall not be less than twenty (20) hours per week; or,
    3. A full-time candidate for licensure as a Tennessee administrator who has completed the required training and the application process. Such candidate shall be scheduled for the next licensure exam and is eligible for the continued administrator role only with the successful completion of that exam.
  - (e) The procedures set forth above shall be followed until the next regularly scheduled meeting of the board in which the board considers the facility’s application for a waiver. After reviewing the circumstances, the board may grant, refuse or condition a waiver as necessary to protect the health, safety and welfare of the residents in the facility.
  - (f) Any facility which follows these procedures shall not be subject to a civil penalty for absence of an administrator at any time preceding the board’s consideration of the facility’s request for a waiver.
- (5) The facility shall make reasonable efforts to safeguard personal property and promptly investigate complaints of such loss. A record shall be prepared of all clothing, personal possessions and money brought by the resident to the nursing home at the time of admission. The record shall be filled out in duplicate. One copy of the record shall be given to the resident or the resident’s representative and the original shall be maintained in the nursing home record. This record shall be updated as additional personal property is brought to the facility.
- (6) The facility shall maintain a surety bond on all resident funds held in trust. Such surety bonds shall be sufficient to cover the amount of such funds. The surety bond shall be an agreement between the company issuing the bond and the nursing home and shall remain in the possession of the nursing home.

(Rule 1200-8-6-.04, continued)

- (7) If the facility holds resident funds, such funds shall be kept in an account separate from the facility's funds. Resident funds shall not be used by the facility. The facility shall maintain and allow each resident access to a written record of all financial arrangements and transactions involving the individual resident's funds. The facility shall provide each resident or his/her representative with a written itemized statement at least quarterly of all financial transactions involving the resident's funds.
- (8) Within thirty (30) days of a resident's death, the facility shall provide an accounting of the resident's funds held by the facility and an inventory of the resident's personal property held by the facility to the resident's executor, administrator or other person authorized by law to receive the decedent's property. The facility shall obtain a signed receipt from any person to whom the decedent's property is transferred.
- (9) Upon the sale of the facility, the seller shall provide written verification that all the resident's funds and property have been transferred and shall obtain a signed receipt from the new owner. Upon receipt, the buyer shall provide, to the residents, an accounting of funds and property held on their behalf.
- (10) When licensure is applicable for a particular job, verification of the current license must be included as a part of the personnel file. Each personnel file shall contain accurate information as to the education, training, experience and personnel background of the employee. Documentation that references were verified shall be on file. Documentation that all appropriate abuse registries have been checked shall be on file. Adequate medical screenings to exclude communicable disease shall be required of each employee.
- (11) Whenever the rules of this chapter require that a licensee develop a written policy, plan, procedure, technique, or system concerning a subject, the licensee shall develop the required policy, maintain it and adhere to its provisions. A nursing home which violates a required policy also violates the rule establishing the requirement.
- (12) Policies and procedures shall be consistent with professionally recognized standards of practice.
- (13) No nursing home shall retaliate against or, in any manner, discriminate against any person because of a complaint made in good faith and without malice to the board, the department, the Department of Human Services Adult Protective Services, the long term care ombudsman, the Comptroller of the State Treasury, or any government agency. A nursing home shall neither retaliate, nor discriminate, because of information lawfully provided to these authorities, because of a person's cooperation with them, or because a person is subpoenaed to testify at a hearing involving one of these authorities.
- (14) Each nursing home shall adopt safety policies for the protection of residents from accident and injury.
- (15) Documentation pertaining to the payment agreement between the nursing home and the resident shall be completed prior to admission. A copy of the documentation shall be given to the resident and the original shall be maintained in the nursing home records.
- (16) The nursing home shall ensure a framework for addressing issues related to care at the end of life.
- (17) The nursing home shall provide a process that assesses pain in all patients. There shall be an appropriate and effective pain management program.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-225, and 68-11-906.  
**Administrative History:** Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Amendment filed May 24, 1985; effective June 23, 1985. Amendment filed March 13, 1986; effective April 12, 1986. Amendment filed October 22, 1987; effective December 6, 1987. Amendment filed May 10, 1990; effective June 24, 1990. Amendment filed March 9, 1992; effective April 23, 1992. Amendment filed March 10, 1995; effective May 24, 1995. Amendment filed June 13, 1997; effective August 27,

(Rule 1200-8-6-.04, continued)

*1997. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed June 18, 2002; effective September 1, 2002.*

**1200-8-6-.05 ADMISSIONS, DISCHARGES, AND TRANSFERS.**

- (1) Every person admitted for care or treatment shall be under the supervision of a physician who holds a license in good standing to practice in Tennessee. The name of the resident's attending physician shall be recorded in the resident's medical record. The nursing home shall not admit the following types of residents:
  - (a) Persons who pose a clearly documented danger to themselves or to other residents in the nursing home.
  - (b) Children under fourteen (14) years of age, except when the department has approved the admission of a specific child.
  - (c) Persons for whom the nursing home is not capable of providing the care ordered by the attending physician. Documentation of the reason(s) for refusal of the admission shall be maintained.
- (2) A diagnosis must be entered in the admission records of the nursing home for every person admitted for care or treatment.
- (3) Facilities utilizing secured units must be able to provide survey staff with twelve (12) months of the following performance information specific to the secured unit and its residents:
  - (a) Documentation that each secured resident has been evaluated by an interdisciplinary team consisting of at least a physician, a social worker, a registered nurse, and a family member (or patient care advocate) prior to admittance to the unit;
  - (b) Ongoing and up-to-date documentation of quarterly review by each resident's interdisciplinary team as to the appropriateness of placement in the secured unit;
  - (c) A current listing of the number of deaths and hospitalizations with diagnoses that have occurred on the unit;
  - (d) A current listing of all unusual incidents and/or complications on the unit;
  - (e) An up-to-date staffing pattern and staff ratios for the unit is recorded on a daily basis. The staffing pattern must ensure that there is a minimum of one (1) attendant, awake, on duty, and physically located on the unit twenty-four (24) hours per day, seven (7) days per week at all times;
  - (f) A formulated calendar of daily group activities scheduled including a resident attendance record for the previous three (3) months;
  - (g) An up-to-date listing of any incidences of decubitus and/or nosocomial infections, including resident identifiers; and,
  - (h) Documentation showing that 100% of the staff working on the unit receives and has received annual in-service training which shall include, but not be limited to the following subject areas:
    1. Basic facts about the causes, progression and management of Alzheimer's Disease and related disorders;

(Rule 1200-8-6-.05, continued)

2. Dealing with dysfunctional behavior and catastrophic reactions in the residents;
  3. Identifying and alleviating safety risks to the resident;
  4. Providing assistance in the activities of daily living for the resident; and,
  5. Communicating with families and other persons interested in the resident.
- (4) The facility shall ensure that no person on the grounds of race, color, national origin, or handicap, will be excluded from participation in, be denied benefits of, or otherwise subjected to discrimination in the provision of any care or service of the facility. The facility shall protect the civil rights of residents under the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.
  - (5) Any admission in excess of the licensed bed capacity is prohibited except when an emergency admission is directed by the department.
  - (6) No resident shall be discharged without a written order from the attending physician or through other legal processes and timely notification of next of kin and/or sponsor or authorized representative, if any. Each nursing home shall establish a policy for handling patients who wish to leave against medical advice.
  - (7) When a resident is discharged, a brief description of the significant findings and events of the resident's stay in the nursing home, the condition on discharge and the recommendation and arrangement for future care, if any, shall be provided.
  - (8) No resident shall be transferred without a written order from the attending physician or through other legal processes and timely notification of next of kin and/or sponsor or authorized representative, if any.
  - (9) When a resident is transferred, a summary of treatment given at the nursing home, condition of the resident at time of transfer and date and place to which he is transferred shall be entered in the record. If the transfer is due to an emergency, this information will be recorded within forty-eight (48) hours, otherwise, it will precede the transfer of the resident.
  - (10) When a resident is transferred, a copy of the clinical summary shall, with consent of the resident, be sent to the nursing home that will continue the care of the resident.
  - (11) Where an involuntary transfer is proposed, in addition to any other relevant factors, the following factors shall be taken into account:
    - (a) The traumatic effect on the resident.
    - (b) The proximity of the proposed nursing home to the present nursing home and to the family and friends of the resident.
    - (c) The availability of necessary medical and social services at the proposed nursing home.
    - (d) Compliance by the proposed nursing home with all applicable Federal and State regulations.
  - (12) When the attending physician has ordered a resident transferred or discharged, but the resident or a representative of the resident opposes the action, the nursing home shall counsel with the resident, the next of kin, sponsor and representative, if any, in an attempt to resolve the dispute and shall not transfer the resident until such counseling has been provided. No involuntary transfer or discharge shall be made until the nursing home has first informed the department and the area long-term care ombudsman. Unless a disaster occurs on the premises or the attending physician orders the transfer as

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a medical emergency (due to the resident's immediate need for a higher level of care) no involuntary transfer or discharge shall be made until five (5) business days after these agencies have been notified, unless they each earlier declare that they have no intention of intervening.

- (13) Except when the Board has revoked or suspended the license, a nursing home which intends to close, cease doing business, or reduce its licensed bed capacity by ten percent (10%) or more shall notify both the department and the area long-term care ombudsman at the earliest moment of the decision, but not later than thirty (30) days before the action is to be implemented. The facility shall establish a protocol, subject to the department's approval, for the transfer or discharge of the residents. Should the nursing home violate the provisions of this paragraph, the department shall request the Attorney General of the State of Tennessee to intervene to protect the residents, as is provided by T.C.A. § 68-11-213(a).

*Authority:* T.C.A. §§4-5-202, 68-11-202, 68-11-204, 68-11-206, and 68-11-209. *Administrative History:* Original rule filed March 27; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed April 10, 2000; effective June 24, 2000.

#### **1200-8-6-.06 BASIC SERVICES.**

- (1) Performance Improvement.
- (a) The nursing home must ensure that there is an effective, facility-wide performance improvement program to evaluate resident care and performance of the organization.
- (b) The performance improvement program must be ongoing and have a written plan of implementation which assures that:
1. All organized services related to resident care, including services furnished by a contractor, are evaluated;
  2. Nosocomial infections and medication therapy are evaluated; and,
  3. All services performed in the facility are evaluated as to the appropriateness of diagnosis and treatment.
- (c) The nursing home must have an ongoing plan, consistent with available community and facility resources, to provide or make available services that meet the medically-related needs of its residents.
- (d) The facility must develop and implement plans for improvement to address deficiencies identified by the performance improvement program and must document the outcome of the remedial action.
- (e) Performance improvement program records are not disclosable, except when such disclosure is required to demonstrate compliance with this section.
- (f) Good faith attempts by the performance improvement program committee to identify and correct deficiencies will not be used as a basis for sanctions.
- (2) Physician Services.
- (a) Policies and procedures concerning services provided by the nursing home shall be available for the admitting physicians.

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- (b) Residents shall be aided in receiving dental care as deemed necessary.
- (c) Each nursing home shall retain by written agreement a physician to serve as a Medical Director.
- (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall:
  - 1. Delineate the responsibilities of and communicate with attending physicians to ensure that each resident receives medical care;
  - 2. Ensure the delivery of emergency and medical care when the resident's attending physician or his/her designated alternate is unavailable;
  - 3. Review reports of all accidents or unusual incidents occurring on the premises, identifying hazards to health and safety and recommending corrective action to the administrator;
  - 4. Make periodic visits to the nursing home to evaluate the existing conditions and make recommendations for improvements;
  - 5. Review and take appropriate action on reports from the Director of Nursing regarding significant clinical developments;
  - 6. Monitor the health status of nursing home personnel to ensure that no health conditions exist which would adversely affect residents; and,
  - 7. Advise and provide consultation on matters regarding medical care, standards of care, surveillance and infection control.
- (3) Infection Control.
  - (a) The nursing home must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.
  - (b) The administrator shall assure that an infection control program including members of the medical staff, nursing staff and administrative staff develop guidelines and techniques for the prevention, surveillance, control and reporting of facility infections. Duties of the program shall include the establishment of:
    - 1. Written infection control policies;
    - 2. Techniques and systems for identifying, reporting, investigating and controlling infections in the facility;
    - 3. Written procedures governing the use of aseptic techniques and procedures in the facility;
    - 4. Written procedures concerning food handling, laundry practices, disposal of environmental and resident wastes, traffic control and visiting rules, sources of air pollution, and routine culturing of autoclaves and sterilizers;
    - 5. A log of incidents related to infectious and communicable diseases;
    - 6. Formal provisions to educate and orient all appropriate personnel in the practice of aseptic techniques such as handwashing, proper grooming, masking, dressing care

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techniques, disinfecting and sterilizing techniques, and the handling and storage of resident care equipment and supplies; and,

7. Continuing education for all facility personnel on the cause, effect, transmission, prevention, and elimination of infections.
- (c) The administrator, the medical staff and director of nursing services must ensure that the facility-wide performance improvement program and training programs address problems identified by the infection control program and must be responsible for the implementation of successful corrective action plans in affected problem areas.
  - (d) The facility shall develop policies and procedures for testing a resident's blood for the presence of the hepatitis B virus and the HIV virus in the event that an employee of the facility, a student studying at the facility, or other health care provider rendering services at the facility is exposed to a resident's blood or other body fluid. The testing shall be performed at no charge to the resident, and the test results shall be confidential.
  - (e) The facility and its employees shall adopt and utilize standard or universal precautions of the Centers for Disease Control (CDC) for preventing transmission of infections, HIV, and communicable diseases.
  - (f) All nursing homes shall adopt appropriate policies regarding the testing of residents and staff for HIV and any other identified causative agent of acquired immune deficiency syndrome.
  - (g) The facility shall document evidence of annual vaccination against influenza for each resident, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control most recent to the time of the vaccine. Influenza vaccination is medically contraindicated or the resident has refused the vaccine. Influenza vaccination for all residents accepting the vaccine shall be completed by November 30 of each year or within ten (10) days of the vaccine becoming available. Residents admitted after this date during the flu season and up to February 1, shall as medically appropriate, receive influenza vaccination prior to or on admission unless refused by the resident.

The facility shall document evidence of vaccination against pneumococcal disease for all residents who are 65 years of age or older, in accordance with the recommendation of the Advisory Committee on Immunization Practices of the Centers for Disease Control at the time of vaccination, unless such vaccination is medically contraindicated or the resident has refused offer of the vaccine. The facility shall provide or arrange the pneumococcal vaccination of residents who have not received this immunization prior to or on admission unless the resident refuses offer of the vaccine.

- (h) Precautions shall be taken to prevent the contamination of sterile supplies by soiled supplies. Sterile supplies shall be packaged and stored in a manner that protects the sterility of the contents. Decontamination and preparation areas shall be separated.
- (i) Space and facilities for housekeeping equipment and supply storage shall be provided in each service area. Storage for bulk supplies and equipment shall be located away from patient care areas. The building shall be kept in good repair, clean, sanitary and safe at all times.
- (j) The facility shall appoint a housekeeping supervisor who shall be responsible for:
  1. Organizing and coordinating the facility's housekeeping service;
  2. Acquiring and storing sufficient housekeeping supplies and equipment for facility maintenance; and,

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3. Assuring the clean and sanitary condition of the facility to provide a safe and hygienic environment for residents and staff. Cleaning shall be accomplished in accordance with the infection control rules herein and facility policy.
- (k) Laundry facilities located in the nursing home shall:
1. Be equipped with an area for receiving, processing, storing and distributing clean linen;
  2. Be located in an area that does not require transportation for storage of soiled or contaminated linen through food preparation, storage or dining areas;
  3. Provide space for storage of clean linen within nursing units and for bulk storage within clean areas of the facility; and,
  4. Provide carts, bags or other acceptable containers appropriately marked to identify those used for soiled linen and those used for clean linen to prevent dual utilization of the equipment and cross contamination.
- (l) The facility shall name an individual who is responsible for laundry service. This individual shall be responsible for:
1. Establishing a laundry service, either within the nursing home or by contract, that provides the facility with sufficient clean, sanitary linen at all times;
  2. Knowing and enforcing infection control rules and regulations for the laundry service;
  3. Assuring the collection, packaging, transportation and storage of soiled, contaminated, and clean linen is in accordance with all applicable infection control rules and procedures; and,
  4. Assuring that a contract laundry service complies with all applicable infection control rules and procedures.
- (4) Nursing Services.
- (a) Each nursing home must have an organized nursing service that provides twenty-four (24) hour nursing services furnished or supervised by a registered nurse. Each home shall have a licensed practical nurse or registered nurse on duty at all times and at least two (2) nursing personnel on duty each shift.
  - (b) The facility must have a well-organized nursing service with a plan of administrative authority and delineation of responsibilities for resident care. The Director of Nursing (DON) must be a licensed registered nurse who has no current disciplinary actions against his/her license. The DON is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the facility.
  - (c) The Director of Nursing shall have the following responsibilities:
    1. Develop, maintain and periodically update:
      - (i) Nursing service objectives and standards of practice;
      - (ii) Nursing service policy and procedure manuals;

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- (iii) Written job descriptions for each level of nursing personnel;
    - (iv) Methods for coordination of nursing service with other resident services; and,
    - (v) Mechanisms for monitoring quality of nursing care, including the periodic review of medical records.
  - 2. Participate in selecting prospective residents in terms of the nursing services they need and nursing competencies available.
  - 3. Make daily rounds to see residents.
  - 4. Notify the resident's physician when medically indicated.
  - 5. Review each resident's medications periodically and notify the physician where changes are indicated.
  - 6. Supervise the administration of medications.
  - 7. Supervise assignments of the nursing staff for the direct care of all residents.
  - 8. Plan, develop and conduct monthly in-service education programs for nursing personnel and other employees of the nursing home where indicated. An organized orientation program shall be developed and implemented for all nursing personnel.
  - 9. Supervise and coordinate the feeding of all residents who need assistance.
  - 10. Coordinate the dietary requirements of residents with the staff responsible for the dietary service.
  - 11. Coordinate housekeeping personnel.
  - 12. Assure that discharge planning is initiated in a timely manner.
  - 13. Assure that residents, along with their necessary medical information, are transferred or referred to appropriate facilities, agencies or outpatient services, as needed, for follow-up or ancillary care.
- (d) The nursing service must have adequate numbers of licensed registered nurses, licensed practical nurses, and certified nurse aides to provide nursing care to all residents as needed. Nursing homes shall provide a minimum of two (2) hours of direct care to each resident every day including 0.4 hours of licensed nursing personnel time. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the availability of a licensed nurse for bedside care of any resident.
- (e) A registered nurse must supervise and evaluate the nursing care for each resident.
- (f) The facility must ensure that an appropriate individualized plan of care is prepared for each resident with input from appropriate disciplines, the resident and/or the resident's family or the resident's representative.
- (g) A registered nurse must assign the nursing care of each resident to other nursing personnel in accordance with the resident's needs and the specialized qualifications and competence of the nursing staff available.

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- (h) Non-employee licensed nurses who are working in the nursing home must adhere to the policies and procedures of the facility. The director of the nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing service.
- (i) All drugs, devices and related materials must be administered by, or under the supervision of, nursing or other personnel in accordance with federal and state laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.
- (j) There must be a facility procedure for reporting adverse drug reactions and errors in administration of drugs.
- (k) When non-employees are utilized as sitters or attendants, they shall be under the authority of the nursing service and their duties shall be set forth clearly in written nursing service policies.
- (l) Each resident shall be given proper personal attention and care of skin, feet, nails and oral hygiene in addition to the specific professional nursing care as ordered by the resident's physician.
- (m) Medications, treatments, and diet shall be carried out as prescribed to safeguard the resident, to minimize discomfort and to attain the physician's objective.
- (n) Residents shall have baths or showers at least two (2) times each week, or more often if requested by the resident.
- (o) Body position of residents in bed or chair bound shall be changed at least every two (2) hours, day and night, while maintaining good body alignment. Proper skin care shall be provided for bony prominences and weight bearing parts to prevent discomfort and the development of pressure areas, unless contraindicated by physician's orders.
- (p) Residents who are incontinent shall have partial baths each time the bed or bed clothing has been wet or soiled. The soiled or wet bed linen and the bed clothing shall be replaced with clean, dry linen and clothing immediately after being soiled.
- (q) Residents shall have shampoos, haircuts and shaves as needed, or desired.
- (r) Rehabilitation measures such as assisting patients with range of motion, prescribed exercises and bowel and bladder retraining programs shall be carried out according to the individual needs and abilities of the resident.
- (s) Residents shall be active and out of bed except when contraindicated by written physician's orders.
- (t) Residents shall be encouraged to achieve independence in activities of daily living, self-care, and ambulation as a part of daily care.
- (u) Residents shall have clean clothing as needed and shall be kept free from odor.
- (v) Residents' weights shall be taken and recorded at least monthly unless contraindicated by a physician's order.
- (w) Physical restraints shall be checked every thirty (30) minutes and released every two (2) hours so the resident may be exercised and offered toilet access.

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- (x) Restraints may be applied or administered to residents only on the signed order of a physician. The signed physician's order must be for a specified and limited period of time and must document the necessity of the restraint. There shall be no standing orders for restraints.
- (y) When a resident's safety or safety of others is in jeopardy, the nurse in charge shall use his/her judgment to use physical restraints if a physician's order cannot be immediately obtained. A written order must be obtained as soon as possible.
- (z) Locked restraints are prohibited.
- (aa) Assistance with eating shall be given to the resident as needed in order for the resident to receive the diet for good health care.
- (bb) Abnormal food intake will be evaluated and recorded.
- (cc) A registered nurse may make the actual determination and pronouncement of death under the following circumstances:
  - 1. The deceased was a resident of a nursing home;
  - 2. The death was anticipated, and the attending physician or nursing home medical director has agreed in writing to sign the death certificate. Such agreement by the attending physician or nursing home medical director must be present with the deceased at the place of death;
  - 3. The nurse is licensed by the state; and,
  - 4. The nurse is employed by the nursing home in which the deceased resided.
- (5) Medical Records.
  - (a) The nursing home shall comply with the Tennessee Medical Records Act, T.C.A. §§ 68-11-301, et seq.
  - (b) The nursing home must maintain a medical record for each resident. Medical records must be accurate, promptly completed, properly filed and retained, and accessible. The facility must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.
  - (c) All medical records, in either written, electronic, graphic or otherwise acceptable form, must be retained in their original or legally reproduced form for a minimum period of at least ten (10) years after which such records may be destroyed. However, in cases of residents under mental disability or minority, their complete facility records shall be retained for the period of minority or known mental disability, plus one (1) year, or ten (10) years following the discharge of the resident, whichever is longer. Records destruction shall be accomplished by burning, shredding or other effective method in keeping with the confidential nature of the contents. The destruction of records must be made in the ordinary course of business, must be documented and in accordance with the facility's policies and procedures, and no record may be destroyed on an individual basis.
  - (d) When a nursing home closes with no plans of reopening, an authorized representative of the facility may request final storage or disposition of the facility's medical records by the department. Upon transfer to the department, the facility relinquishes all control over final storage of the records and the files shall become property of the State of Tennessee.

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- (e) The nursing home must have a system of coding and indexing medical records. The system must allow for timely retrieval by diagnosis and procedure.
  - (f) The nursing home must have a procedure for ensuring the confidentiality of resident records. Information from or copies of records may be released only to authorized individuals, and the facility must ensure that unauthorized individuals cannot gain access to or alter resident records. Original medical records must be released by the facility only in accordance with federal and state laws, court orders or subpoenas.
  - (g) The medical record must contain information to justify admission, support the diagnosis, and describe the resident's progress and response to medications and services.
  - (h) All entries must be legible, complete, dated and authenticated according to facility policy.
  - (i) All records must document the following:
    - 1. Evidence of a physical examination, including a health history, performed no more than thirty (30) days prior to admission or within forty-eight (48) hours following admission;
    - 2. Admitting diagnosis;
    - 3. A dietary history as part of each resident's admission record;
    - 4. Results of all consultative evaluations of the resident and appropriate findings by clinical and other staff involved in the care of the resident;
    - 5. Documentation of complications, facility acquired infections, and unfavorable reactions to drugs;
    - 6. Properly executed informed consent forms for procedures and treatments specified by facility policy, or by federal or state law if applicable, as requiring written resident consent;
    - 7. All practitioners' orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the resident's condition;
    - 8. Discharge summary with disposition of case and plan for follow-up care; and,
    - 9. Final diagnosis with completion of medical records within thirty (30) days following discharge.
  - (j) Electronic and computer-generated records and signature entries are acceptable.
- (6) Pharmaceutical Services.
- (a) The nursing home shall have pharmaceutical services that meet the needs of the residents and are in accordance with the Tennessee Board of Pharmacy statutes and rules. The medical staff is responsible for developing policies and procedures that minimize drug errors.
  - (b) All internal and external medications and preparations intended for human use shall be stored separately. They shall be properly stored in medicine compartments, including cabinets on wheels, or drug rooms. Such cabinets or drug rooms shall be kept securely locked when not in use, and the key must be in the possession of the supervising nurse or other authorized persons.

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- Poisons or external medications shall not be stored in the same compartment and shall be labeled as such.
- (c) Schedule II drugs must be stored behind two (2) separately locked doors at all times and accessible only to persons in charge of administering medication.
  - (d) Every nursing home shall comply with all state and federal regulations governing Schedule II drugs.
  - (e) A notation shall be made in a Schedule II drug book and in the resident's nursing notes each time a Schedule II drug is given. The notation shall include the name of the resident receiving the drug, name of the drug, the dosage given, the method of administration, the date and time given and the name of the physician prescribing the drug.
  - (f) All oral orders shall be immediately recorded, designated as such and signed by the person receiving them and countersigned by the physician within ten (10) days.
  - (g) All orders for drugs, devices and related materials must be in writing and signed by the practitioner or practitioners responsible for the care of the resident. Electronic and computer-generated records and signature entries are acceptable. When telephone or oral orders must be used, they shall be:
    - 1. Accepted only by personnel that are authorized to do so by the medical staff policies and procedures, consistent with federal and state law; and,
    - 2. Signed or initialed by the prescribing practitioner according to nursing home policy.
  - (h) Medications not specifically limited as to time or number of doses when ordered are controlled by automatic stop orders or other methods in accordance with written policies. No Schedule II drug shall be given or continued beyond seventy-two (72) hours without a written order by the physician.
  - (i) Medication administration records (MAR) shall be checked against the physician's orders. Each dose shall be properly recorded in the clinical record after it has been administered.
  - (j) Preparation of doses for more than one scheduled administration time shall not be permitted.
  - (k) Medication shall be administered only by licensed medical or licensed nursing personnel or other licensed health professionals acting within the scope of their licenses.
  - (l) Unless the unit dose package system is used, individual prescriptions of drugs shall be kept in the original container with the original label intact showing the name of the resident, the drug, the physician, the prescription number and the date dispensed.
  - (m) Legend drugs shall be dispensed by a licensed pharmacist.
  - (n) Any unused portions of prescriptions shall be turned over to the resident only on a written order by the physician. A notation of drugs released to the resident shall be entered into the medical record. All unused prescriptions left in a nursing home must be destroyed on the premises and recorded by a pharmacist. Such record shall be kept in the nursing home.
- (7) Radiology Services. The nursing home must maintain or have available diagnostic radiologic services according to the needs of the residents. If therapeutic services are also provided, they, as well as the diagnostic services, must meet professionally approved standards for safety and personnel qualifications.

(Rule 1200-8-6-.06, continued)

- (8) Laboratory Services. The nursing home must maintain or have available, either directly or through a contractual agreement, adequate laboratory services to meet the needs of the residents. The nursing home must ensure that all laboratory services provided to its residents are performed in a facility licensed in accordance with the Tennessee Medical Laboratory Act (TMLA). All technical laboratory staff shall be licensed in accordance with the TMLA and shall be qualified by education, training and experience for the type of services rendered.
- (9) Food and Dietetic Services.
- (a) The nursing home must have organized dietary services that are directed and staffed by adequate qualified personnel. A facility may contract with an outside food management company if the company has a dietitian who serves the facility on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this paragraph and provides for constant liaison with the facility medical staff for recommendations on dietetic policies affecting resident treatment. If an outside contract is utilized for management of its dietary services, the facility shall designate a full-time employee to be responsible for the overall management of the services.
- (b) The nursing home must designate a person, either directly or by contractual agreement, to serve as the food and dietetic services director with responsibility for the daily management of the dietary services. The food and dietetic services director shall be:
1. A qualified dietitian; or,
  2. A graduate of a dietetic technician or dietetic assistant training program, correspondence or classroom, approved by the American Dietetic Association; or,
  3. A graduate of a state-approved course that provided ninety (90) or more hours of classroom instruction in food service supervision and who has experience as a food service supervisor in a health care institution with consultation from a qualified dietitian.
- (c) There must be a qualified dietitian, full time, part-time, or on a consultant basis, who is responsible for the development and implementation of a nutrition care process to meet the needs of residents for health maintenance, disease prevention and, when necessary, medical nutrition therapy to treat an illness, injury or condition. Medical nutrition therapy includes assessment of the nutritional status of the resident and treatment through diet therapy, counseling and/or use of specialized nutrition supplements.
- (d) Menus must meet the needs of the residents.
1. Therapeutic diets must be prescribed by the practitioner or practitioners responsible for the care of the residents and must be prepared and served as prescribed.
  2. Special diets shall be prepared and served as ordered.
  3. Nutritional needs must be met in accordance with recognized dietary practices and in accordance with orders of the practitioner or practitioners responsible for the care of the residents.
  4. A current therapeutic diet manual approved by the dietitian and medical staff must be readily available to all medical, nursing, and food service personnel.
- (e) Education programs, including orientation, on-the-job training, inservice education, and continuing education shall be offered to dietetic services personnel on a regular basis. Programs

(Rule 1200-8-6-.06, continued)

shall include instruction in the use of equipment, personal hygiene, proper inspection, and the handling, preparing and serving of food.

- (f) A minimum of three (3) meals in each twenty-four (24) hour period shall be served. A supplemental night meal shall be served if more than fourteen (14) hours lapse between supper and breakfast. Additional nourishments shall be provided to patients with special dietary needs. A minimum of three (3) days supply of food shall be on hand.
  - (g) Menus shall be prepared at least one week in advance. A dietitian shall be consulted to help write and plan the menus. If any change in the actual food served is necessary, the change shall be made on the menu to designate the foods actually served to the residents. Menus of food served shall be kept on file for a thirty (30) day period.
  - (h) The dietitian or designee shall have a conference, dated on the medical chart, with each resident and/or family within two (2) weeks of admission to discuss the diet plan indicated by the physician. The resident's dietary preferences shall be recorded and utilized in planning his/her daily menu.
  - (i) Food shall be protected from dust, flies, rodents, unnecessary handling, droplet infection, overhead leakage and other sources of contamination whether in storage or while being prepared and served and/or transported through hallways.
  - (j) Perishable food shall not be allowed to stand at room temperature except during necessary periods of preparation or serving. Prepared foods shall be kept hot (140°F or above) or cold (45°F or less). Appropriate equipment for temperature maintenance, such as hot and cold serving units or insulated containers, shall be used.
  - (k) All nursing homes shall have commercial automatic dishwashers approved by the National Sanitation Foundation. Dishwashing machines shall be used according to manufacturer specifications.
  - (l) All dishes, glassware and utensils used in the preparation and serving of food and drink shall be cleaned and sanitized after each use.
  - (m) The cleaning and sanitizing of handwashed dishes shall be accomplished by using a three-compartment sink according to the current "U.S. Public Health Service Sanitation Manual".
  - (n) The kitchen shall contain sufficient refrigeration equipment and space for the storage of perishable foods.
  - (o) All refrigerators and freezers shall have thermometers. Refrigerators shall be kept at a temperature not to exceed 45°F. Freezers shall be kept at a temperature not to exceed 0°F.
  - (p) Written policies and procedures shall be followed concerning the scope of food services in accordance with the current edition of the "U.S. Public Health Service Recommended Ordinance and Code Regulating Eating and Drinking Establishments" and the current "U.S. Public Health Service Sanitation Manual" should be used as a guide to food sanitation.
- (10) Social Work Services.
- (a) Social services must be available to the resident, the resident's family and other persons significant to the resident, in order to facilitate adjustment of these individuals to the impact of illness and to promote maximum benefits from the health care services provided.

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- (b) Social work services shall include psychosocial assessment, counseling, coordination of discharge planning, community liaison services, financial assistance and consultation.
  - (c) A resident's social history shall be obtained within two (2) weeks of admission and shall be appropriately maintained.
  - (d) Social work services shall be provided by a qualified social worker.
  - (e) Facilities for social work services shall be readily accessible and shall permit privacy for interviews and counseling.
- (11) Physical, Occupational and Speech Therapy Services.
- (a) Physical therapy, occupational therapy and speech therapy shall be provided directly or through contractual agreement by individuals who meet the qualifications specified by nursing home policy, consistent with state law.
  - (b) A licensed physical therapist shall be in charge of the physical therapy service and a licensed occupational therapist shall be in charge of the occupational therapy service.
  - (c) Direct contact shall exist between the resident and the therapist for those residents that require treatment ordered by a physician.
  - (d) The physical therapist and occupational therapist, pursuant to a physician order, shall provide treatment and training designed to preserve and improve abilities for independent functions, such as: range of motion, strength, tolerance, coordination and activities of daily living.
  - (e) Therapy services shall be coordinated with the nursing service and made a part of the resident care plan.
  - (f) Sufficient staff shall be made available to provide the service offered.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-3-511, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.  
**Administrative History:** Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Amendment filed March 13, 1986; effective April 12, 1986. Amendment filed January 29, 1991; effective March 15, 1991. Amendment filed December 29, 1992; effective February 15, 1993. Amendment filed June 15, 1993; effective July 30, 1993. Amendment filed April 17, 1996; effective July 1, 1996. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed January 31, 2000; effective April 15, 2000. Amendment filed March 29, 2000; effective June 12, 2000. Amendment filed September 13, 2002; effective November 27, 2002. Amendment filed September 4, 2003; effective November 18, 2003.

**1200-8-6-.07 SPECIAL SERVICES: ALZHEIMER'S UNITS.** Structurally distinct parts of a nursing home may be designated as special care units for ambulatory residents with dementia or Alzheimer's Disease and related disorders. Such units shall be designed to encourage self-sufficiency, independence and decision-making skills, and may admit residents only after the unit is found to be in compliance with licensure standards and upon final approval by the department. Units which hold themselves out to the public as providing specialized Alzheimer's services shall comply with the provisions of T.C.A. § 68-11-1404 and shall be in compliance with the following minimum standards:

- (1) In order to be admitted to the special care unit:
  - (a) A diagnosis of dementia must be made by a physician. The specific etiology causing the dementia shall be identified to the best level of certainty prior to admission to the special care unit; and,

(Rule 1200-8-6-.07, continued)

- (b) The need for admission must be determined by an interdisciplinary team consisting at least of a physician experienced in the management of residents with Alzheimer's Disease and related disorders, a social worker, a registered nurse and a relative of the resident or a resident care advocate.
- (2) Special care units shall be separated from the remaining portion of the nursing home by a locked door and must have extraordinary and acceptable fire safety features and policies which ensure the well being and protection of the residents.
- (3) The residents must have direct access to a secured, therapeutic outdoor area. This outdoor area shall be designed and maintained to facilitate emergency evacuation.
- (4) There must be limited access to the designated unit so that visitors and staff do not pass through the unit to get to other areas of the nursing home.
- (5) Each unit must contain a designated dining/activity area which shall accommodate 100% seating for residents.
- (6) Corridors or open spaces shall be designed to facilitate ambulation and activity, and shall have an unobstructed view from the central working or nurses' station.
- (7) Drinking facilities shall be provided in the central working area or nurses' station and in the primary activities areas. Glass front refrigerators may be used.
- (8) The unit shall be designed, equipped and maintained to promote positive resident response through the use of:
  - (a) Reduced-glare lighting, wall and floor coverings, and materials and decorations conducive to appropriate sensory and visual stimulation; and,
  - (b) Meaningful wandering space shall be provided that encourages physical exercise and ensures that residents will not become frustrated upon reaching dead-ends.
- (9) The designated units shall provide a minimum of 3.5 hours of direct care to each resident every day including .75 hours of licensed nursing personnel time. Direct care shall not be limited to nursing personnel time and may include direct care provided by dietary employees, social workers, administrator, therapists and other care givers, including volunteers.
- (10) In addition to the classroom instruction required in the nurse aide training program, each nurse aide assigned to the unit shall have forty (40) hours of classroom instruction which shall include but not be limited to the following subject areas:
  - (a) Basic facts about the causes, progression and management of Alzheimer's Disease and related disorders;
  - (b) Dealing with dysfunctional behavior and catastrophic reactions in the resident;
  - (c) Identifying and alleviating safety risks to the resident;
  - (d) Providing assistance in the activities of daily living for the resident; and,
  - (e) Communicating with families and other persons interested in the resident.
- (11) Each resident shall have a treatment plan developed, periodically reviewed and implemented by an interdisciplinary treatment team consisting at least of a physician experienced in the management of

(Rule 1200-8-6-.07, continued)

residents with Alzheimer's Disease and related disorders, a registered nurse, a social worker, an activity coordinator and a relative of the resident or a resident care advocate.

- (12) A protocol for identifying and alleviating job related stress among staff on the special care unit must be developed and carried out.
- (13) The staff of the unit shall organize a support group for families of residents which meets at least quarterly for the purpose of:
  - (a) Providing ongoing education for families;
  - (b) Permitting families to give advice about the operation of the unit;
  - (c) Alleviating stress in family members; and
  - (d) Resolving special problems relating to the residents in the unit.

**Authority:** T.C.A. §§4-5-202, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-1404. **Administrative History:** Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Repeal and new rule filed January 31, 2000; effective April 15, 2000.

#### **1200-8-6-.08 BUILDING STANDARDS.**

- (1) The nursing home must be constructed, arranged and maintained to ensure the safety of the resident.
- (2) After the application and licensure fees have been submitted, the building construction plans must be submitted to the department. All new facilities shall conform to the 1999 edition of the Standard Building Code (excluding Chapter I, Administration and Chapter 11, Handicapped Accessibility), the handicap code as required by T.C.A. §68-18-204(a), the most recent edition of the ASHRAE Handbook of Fundamentals, and the 2000 edition of the National Fire Protection Code (NFPA), NFPA 1 including Annex A, the 1999 National Electrical Code and the 2001 Edition of the Guidelines for Design and Construction of Hospital and Health Care Facilities. When referring to height, area or construction type, the Standard Building Code shall prevail. All new and existing facilities are subject to the requirements of the Americans with Disabilities Act (A.D.A.). Where there are conflicts between requirements in the above listed codes and regulations and provisions of this chapter, the most restrictive shall apply.
- (3) All new construction and renovations to existing nursing homes, other than alterations not affecting fire and life safety or functional issues, shall be performed in accordance with the specific requirements of these rules governing new construction in nursing homes, including the submission of phased construction plans and the final work drawings and the specifications to each.
- (4) No new nursing home shall be constructed, nor shall major alterations be made to existing nursing homes, without the prior written approval of the department, and unless in accordance with plans and specifications approved in advance by the department. Before any new nursing home is licensed or before any alteration or expansion of a licensed nursing home can be approved, the applicant must furnish two (2) complete sets of plans and specifications to the department, together with fees and other information as required. Plans and specifications for new construction and major renovations, other than minor alterations not affecting fire and life safety or functional issues shall be prepared by or under the direction of a licensed architect and/or a qualified licensed engineer.
- (5) In the event that submitted materials do not appear to satisfactorily comply with 1200-8-6-.08(2) the department shall furnish a letter to the party submitting the plans which shall list the particular items in question and request further explanation and/or confirmation of necessary modifications.

(Rule 1200-8-6-.08, continued)

- (6) The codes in effect at the time of submittal of plans and specifications shall be the codes to be used throughout the project.
- (7) Detailed plans shall be drawn to a scale of at least one-eighth inch equals one foot ( $1/8'' = 1'$ ), and shall show the general arrangement of the building, the intended purpose and the fixed equipment in each room, with such additional information as the department may require. These plans shall be prepared by an architect or engineer licensed to practice in the State of Tennessee. The plans shall contain a certificate signed by the architect or engineer that to the best of his or her knowledge or belief the plans conform to all applicable codes.
  - (a) Two sets of plans shall be forwarded to the appropriate section of the department for review. After receipt of approval of the plans, the owner may proceed with site grading and foundation work prior to receipt of approval of final plans and specifications with the understanding that such work is at the owner's risk and without assurance that final approval of final plans and specifications shall be granted. Final plans and specifications shall be submitted for review and approval. Final approval must be received before proceeding beyond foundation work.
  - (b) Review of plans does not eliminate the responsibility of the owner and/or the architect to comply with all rules.
- (8) Specifications shall supplement all drawings. They shall describe the characteristics of all materials, products and devices, unless fully described and indicated on the drawings. Specification copies shall be bound in an 8½ x 11 inch folder.
- (9) Final review of plans and specifications shall be acknowledged in writing with copies sent to the architect and the owner, manager or other executive of the institution. The distribution of such review may be modified at the discretion of the department.
- (10) All construction shall be executed in accordance with the completed plans and specifications.
- (11) Drawings and specifications shall be prepared for each of the following branches of work: Architectural, Structural, Mechanical and Electrical.
- (12) Architectural drawings shall include:
  - (a) Plot plan(s) showing property lines, finish grade, location of existing and proposed structures, roadways, walks, utilities and parking areas;
  - (b) Floor plan(s) showing scale drawings of typical and special rooms, indicating all fixed and movable equipment and major items of furniture;
  - (c) Separate life safety plans showing the compartment(s), all means of egress and exit markings, exits and travel distances, dimensions of compartments and calculation and tabulation of exit units. All fire and smoke walls must be color-coded;
  - (d) The elevation of each facade;
  - (e) The typical sections throughout the building;
  - (f) The schedule of finishes;
  - (g) The schedule of doors and windows;
  - (h) Roof plans;

(Rule 1200-8-6-.08, continued)

- (i) Details and dimensions of elevator shaft(s), car platform(s), doors, pit(s), equipment in the machine room, and the rates of car travel must be indicated for elevators; and,
  - (j) Code analysis.
- (13) Structural drawings shall include:
- (a) Plans of foundations, floors, roofs and intermediate levels which show a complete design with sizes, sections and the relative location of the various members; and,
  - (b) Schedules of beams, girders and columns.
- (14) Mechanical drawings shall include:
- (a) Specifications which show the complete heating, ventilating, fire protection, medical gas and air conditioning systems;
  - (b) Water supply, sewerage and HVAC piping systems;
  - (c) Pressure relationships which shall be shown on all floor plans;
  - (d) Heating, ventilating, HVAC piping, medical gas and air conditioning systems with all related piping and auxiliaries to provide a satisfactory installation;
  - (e) Water supply, sewage and drainage with all lines, risers, catchbasins, manholes and cleanouts clearly indicated as to location, size, capacities, etc., and location and dimensions of septic tank and disposal field; and,
  - (f) Color coding to show clearly supply, return and exhaust systems.
- (15) Electrical drawings shall include:
- (a) A certification that all electrical work and equipment are in compliance with all applicable local codes and laws, and that all materials are currently listed by recognized testing laboratories;
  - (b) All electrical wiring, outlets, riser diagrams, switches, special electrical connections, electrical service entrance with service switches, service feeders and characteristics of the light and power current, and transformers when located within the building;
  - (c) The electrical system, which shall comply with applicable codes, and shall include:
    - 1. The nurses call system;
    - 2. The paging system;
    - 3. The fire alarm system; and,
    - 4. The emergency power system including automatic services as defined by the codes.
  - (d) Color coding to show all items on emergency power.
- (16) Final working drawings and specifications shall be accurately dimensioned and include all necessary explanatory notes, schedules and legends. The working drawings and specifications shall be complete and adequate for contract purposes. One (1) set of final plans shall be submitted to the department, after final approval is given but prior to occupancy, in such a form as approved by the department.

(Rule 1200-8-6-.08, continued)

- (17) No system of water supply, plumbing, sewage, garbage or refuse disposal shall be installed nor shall any existing system be materially altered or extended until complete plans and specifications for the installation, alteration or extension have been submitted to the department and show that all applicable codes have been met and necessary approval has been obtained
  - (a) Before the facility is used, the water supply system shall be approved by the Tennessee Department of Environment and Conservation.
  - (b) Sewage shall be discharged into a municipal system or approved package system where available; otherwise, the sewage shall be treated and disposed of in a manner of operation approved by the Department of Environment and Conservation and shall comply with existing codes, ordinances and regulations which are enforced by cities, counties or other areas of local political jurisdiction.
- (18) Construction and renovation projects shall provide for the safety and protection of residents and personnel.
- (19) Construction, equipment, and installation of dietary facilities shall comply with the standards specified in the current Public Health Service "Food Service Sanitation Manual."
- (20) The physical environment must be maintained in such a manner to assure the safety and well being of the residents.
  - (a) Any condition on the nursing home site conducive to the harboring or breeding of insects, rodents or other vermin shall be prohibited. Chemical substances of a poisonous nature used to control or eliminate vermin shall be properly identified. Such substances shall not be stored with or near food or medications.
  - (b) Cats, dogs or other animals shall not be allowed in any part of the facility except for specially trained animals for the handicapped and except as addressed by facility policy for pet therapy programs. The facility shall designate in its policies and procedures those areas where animals will be excluded. The areas designated shall be determined based upon an assessment of the facility performed by medically trained personnel.
  - (c) Telephones shall be readily accessible and at least one (1) shall be equipped with sound amplification and shall be accessible to wheelchair residents.
  - (d) Equipment and supplies for physical examination and emergency treatment of residents shall be available.
  - (e) A bed complete with mattress and pillow shall be provided. In addition, resident units shall be provided with at least one chair, a bedside table, an over bed tray and adequate storage space for toilet articles, clothing and personal belongings.
  - (f) Individual wash cloths, towels and bed linens must be provided for each resident. Linen shall not be interchanged from resident to resident until it has been properly laundered.
  - (g) Bath basin water service, emesis basin, bedpan and urinal shall be individually provided.
  - (h) Water pitchers, glasses, thermometers, emesis basins, douche apparatus, enema apparatus, urinals, mouthwash cups, bedpans and similar items of equipment coming into intimate contact with residents shall be disinfected or sterilized after each use unless individual equipment for each is provided and then sterilized or disinfected between residents and as often as necessary to

(Rule 1200-8-6-.08, continued)

maintain them in a clean and sanitary condition. Single use, resident disposable items are acceptable but shall not be reused.

- (i) The facility shall have written policies and procedures governing care of residents during the failure of the air conditioning, heating or ventilation system, including plans for hypothermia and hyperthermia. When the temperature of any resident area falls below 65°F. or exceeds 85°F., or is reasonably expected to do so, the facility shall be alerted to the potential danger, and the department shall be notified.

**Authority:** T.C.A. §§4-5-202, 68-11-202, 68-11-204, 68-11-206, and 68-11-209. **Administrative History:** Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Amendment filed July 3, 1984; effective August 1, 1984. Amendment filed March 13, 1986; effective April 12, 1986. Amendment filed October 22, 1987; effective December 6, 1987. Amendment filed February 11, 1992; effective March 27, 1992. Amendment filed January 6, 1995; effective March 22, 1995. Amendment filed June 13, 1997; effective August 27, 1997. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed February 18, 2003; effective May 4, 2003.

#### **1200-8-6-.09 LIFE SAFETY.**

- (1) Any nursing home which complies with the required applicable building and fire safety rules at the time the board adopts new codes or rules will, so long as such compliance is maintained either with or without waivers of specific provisions, be considered to be in compliance with the requirements of the new codes or rules.
- (2) The nursing home shall provide fire protection by the elimination of fire hazards, by the installation of necessary fire fighting equipment and by the adoption of a written fire control plan.

**Authority:** T.C.A. §§4-5-202, 68-11-202, 68-11-204, 68-11-206, and 68-11-209. **Administrative History:** Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Repeal and new rule filed January 31, 2000; effective April 15, 2000.

#### **1200-8-6-.10 INFECTIOUS AND HAZARDOUS WASTE.**

- (1) Each nursing home must develop, maintain and implement written policies and procedures for the definition and handling of its infectious and hazardous wastes. These policies and procedures must comply with the standards of this section and all other applicable state and federal regulations.
- (2) The following waste shall be considered to be infectious waste:
  - (a) Waste contaminated by residents who are isolated due to communicable disease, as provided in the U.S. Centers for Disease Control "Guidelines for Isolation Precautions in Hospitals";
  - (b) Cultures and stocks of infectious agents including specimen cultures collected from medical and pathological laboratories, cultures and stocks of infectious agents from research and industrial laboratories, waste from the production of biologicals, discarded live and attenuated vaccines, culture dishes and devices used to transfer, inoculate, and mix cultures;
  - (c) Waste human blood and blood products such as serum, plasma, and other blood components;
  - (d) All discarded sharps (e.g., hypodermic needles, syringes, pasteur pipettes, broken glass, scalpel blades) used in resident care or which have come into contact with infectious agents during use in medical, research, or industrial laboratories; or,
  - (e) Other waste determined to be infectious by the facility in its written policy.

(Rule 1200-8-6-.10, continued)

- (3) Infectious and hazardous waste must be segregated from other waste at the point of generation, i.e., the point at which the material becomes a waste within the facility.
- (4) Waste must be packaged in a manner that will protect waste handlers and the public from possible injury and disease that may result from exposure to the waste. Such packaging must provide for containment of the waste from the point of generation up to the point of proper treatment or disposal. Packaging must be selected and utilized for the type of waste the package will contain, how the waste will be treated and disposed, and how it will be handled and transported prior to treatment and disposal.
  - (a) Contaminated sharps must be directly placed in leakproof, rigid, and puncture-resistant containers which must then be tightly sealed.
  - (b) Whether disposable or reusable, all containers, bags, and boxes used for containment and disposal of infectious waste must be conspicuously identified. Packages containing infectious waste which pose additional hazards (e.g., chemical, radiological) must also be conspicuously identified to clearly indicate those additional hazards.
  - (c) Reusable containers for infectious waste must be thoroughly sanitized each time they are emptied, unless the surfaces of the containers have been completely protected from contamination by disposable liners or other devices removed with the waste.
  - (d) Opaque packaging must be used for pathological waste.
- (5) After packaging, waste must be handled and transported by methods ensuring containment and preserving the integrity of the packaging, including the use of secondary containment where necessary.
  - (a) Infectious waste must not be compacted or ground (i.e., in a mechanical grinder) prior to treatment, except that pathological waste may be ground prior to disposal.
  - (b) Plastic bags of infectious waste must be transported by hand.
- (6) Waste must be stored in a manner which preserves the integrity of the packaging, inhibits rapid microbial growth and putrefaction, and minimizes the potential of exposure or access by unknowing persons. Waste must be stored in a manner and location which affords protection from animals, precipitation, wind, and direct sunlight, does not present a safety hazard, does not provide a breeding place or food source for insects or rodents and does not create a nuisance.
- (7) In the event of spills, ruptured packaging, or other incidents where there is a loss of containment of waste, the facility must ensure that proper actions are immediately taken to:
  - (a) Isolate the area from the public and all except essential personnel;
  - (b) To the extent practicable, repackage all spilled waste and contaminated debris in accordance with the requirements of this rule;
  - (c) Sanitize all contaminated equipment and surfaces appropriately. Written policies and procedures must specify how this will be done; and,
  - (d) Complete an incident report and maintain a copy on file.
- (8) Except as provided otherwise in this rule, a facility must treat or dispose of infectious waste by one or more of the methods specified in this paragraph.

(Rule 1200-8-6-.10, continued)

- (a) A facility may treat infectious waste in an on-site sterilization or disinfection device, or in an incinerator or a steam sterilizer, which has been designed, constructed, operated and maintained so that infectious waste treated in such a device is rendered non-infectious and is, if applicable, authorized for that purpose pursuant to current rules of the Department of Environment and Conservation. A valid permit or other written evidence of having complied with the Tennessee Air Pollution Control Regulations shall be available for review, if required. Each sterilizing or disinfection cycle must contain appropriate indicators to assure conditions were met for proper sterilization or disinfection of materials included in the cycle, and records kept. Proper operation of such devices must be verified at least monthly, and records of these monthly checks shall be available for review. Waste that contains toxic chemicals that would be volatilized by steam must not be treated in steam sterilizers. Infectious waste that has been rendered to carbonized or mineralized ash shall be deemed non-infectious. Unless otherwise hazardous and subject to the hazardous waste management requirements of the current rules of the Department of Environment and Conservation, such ash shall be disposable as a non-hazardous solid waste under current rules of the Department of Environment and Conservation.
  - (b) The facility may discharge liquid or semi-liquid infectious waste to the collection sewerage system of a wastewater treatment facility which is subject to a permit pursuant to T.C.A. § 69-3-101, et seq., provided that such discharge is in accordance with any applicable terms of that permit and/or any applicable municipal sewer use requirements.
  - (c) Any health care facility accepting waste from another state must promptly notify the Department of Environment and Conservation, county, and city public health agencies, and must strictly comply with all applicable local, state and federal regulations.
- (9) The facility may have waste transported off-site for storage, treatment, or disposal. Such arrangements must be detailed in a written contract, available for review. If such off-site location is in Tennessee, the facility must ensure that it has all necessary state and local approvals, and such approvals shall be available for review. If the off-site location is in another state, the facility must notify in writing all public health agencies with jurisdiction that the location is being used for management of the facility's waste. Waste shipped off-site must be packaged in accordance with applicable federal and state requirements. Waste transported to a sanitary landfill in this state must meet the requirements of current rules of the Department of Environment and Conservation.
- (10) All garbage, trash and other non-infectious waste shall be stored and disposed of in a manner that shall not permit the transmission of disease, create a nuisance, provide a breeding place for insects and rodents, or constitute a safety hazard. All containers for waste shall be water tight, constructed of easily cleanable material and shall be kept on elevated platforms.

**Authority:** T.C.A. §§ 4-5-202, 68-11-202, 68-11-204, 68-11-206, and 68-11-209. **Administrative History:** Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Amendment filed July 3, 1984; effective August 1, 1984. Amendment filed March 13, 1986; effective April 12, 1986. Amendment filed October 22, 1987; effective December 6, 1987. Amendment filed February 11, 1992; effective March 27, 1992. Amendment filed January 6, 1995; effective March 22, 1995. Amendment filed June 13, 1997; effective August 27, 1997. Repeal and new rule filed January 31, 2000; effective April 15, 2000.

#### **1200-8-6-.11 RECORDS AND REPORTS.**

- (1) The nursing home shall report each case of communicable disease to the local county health officer in the manner provided by existing regulations. Failure to report a communicable disease may result in disciplinary action, including revocation of the facility's license.
- (2) Unusual events shall be reported by the facility to the Department of Health in a format designed by the Department within seven (7) business days of the date of the identification of the abuse of a patient

(Rule 1200-8-6-.11, continued)

or an unexpected occurrence or accident that results in death, life threatening or serious injury to a patient.

- (a) The following represent circumstances that could result in an unusual event that is an unexpected occurrence or accident resulting in death, life threatening or serious injury to a patient, not related to a natural course of the patient's illness or underlying condition. The circumstances that could result in an unusual event include, but are not limited to:
1. medication errors;
  2. aspiration in a non-intubated patient related to conscious/moderate sedation;
  3. intravascular catheter related events including necrosis or infection requiring repair or intravascular catheter related pneumothorax;
  4. volume overload leading to pulmonary edema;
  5. blood transfusion reactions, use of wrong type of blood and/or delivery of blood to the wrong patient;
  6. perioperative/periprocedural related complication(s) that occur within 48 hours of the operation or the procedure, including a procedure which results in any new central neurological deficit or any new peripheral neurological deficit with motor weakness;
  7. burns of a second or third degree;
  8. falls resulting in radiologically proven fractures, subdural or epidural hematoma, cerebral contusion, traumatic subarachnoid hemorrhage, and/or internal trauma, but does not include fractures resulting from pathological conditions;
  9. procedure related incidents, regardless of setting and within thirty (30) days of the procedure and includes readmissions, which include:
    - (i) procedure related injury requiring repair or removal of an organ;
    - (ii) hemorrhage;
    - (iii) displacement, migration or breakage of an implant, device, graft or drain;
    - (iv) post operative wound infection following clean or clean/contaminated case;
    - (v) any unexpected operation or reoperation related to the primary procedure;
    - (vi) hysterectomy in a pregnant woman;
    - (vii) ruptured uterus;
    - (viii) circumcision;
    - (ix) incorrect procedure or incorrect treatment that is invasive;
    - (x) wrong patient/wrong site surgical procedure;
    - (xi) unintentionally retained foreign body;

(Rule 1200-8-6-.11, continued)

- (xii) loss of limb or organ, or impairment of limb if the impairment is present at discharge or for at least two (2) weeks after occurrence;
  - (xiii) criminal acts;
  - (xiv) suicide or attempted suicide;
  - (xv) elopement from the facility;
  - (xvi) infant abduction, or infant discharged to the wrong family;
  - (xvii) adult abduction;
  - (xviii) rape;
  - (xix) patient altercation;
  - (xx) patient abuse, patient neglect, or misappropriation of resident/patient funds;
  - (xxi) restraint related incidents; or
  - (xxii) poisoning occurring within the facility.
- (b) Specific incidents that might result in a disruption of the delivery of health care services at the facility shall also be reported to the department, on the unusual event form, within seven (7) days after the facility learns of the incident. These specific incidents include the following:
1. strike by the staff at the facility;
  2. external disaster impacting the facility;
  3. disruption of any service vital to the continued safe operation of the facility or to the health and safety of its patients and personnel; and
  4. fires at the facility which disrupt the provision of patient care services or cause harm to patients or staff, or which are reported by the facility to any entity, including but not limited to a fire department, charged with preventing fires.
- (c) For health services provided in a “home” setting, only those unusual events actually witnessed or known by the person delivering health care services are required to be reported.
- (d) Within forty (40) days of the identification of the event, the facility shall file with the department a corrective action report for the unusual event reported to the department. The department’s approval of a Corrective Action Report will take into consideration whether the facility utilized an analysis in identifying the most basic or causal factor(s) that underlie variation in performance leading to the unusual event by (a) determining the proximate cause of the unusual event, (b) analyzing the systems and processes involved in the unusual event, (c) identifying possible common causes, (d) identifying potential improvements, and (e) identifying measures of effectiveness. The corrective action report shall either: (1) explain why a corrective action report is not necessary; or (2) detail the actions taken to correct any error identified that contributed to the unusual event or incident, the date the corrections were implemented, how the facility will prevent the error from recurring in the future and who will monitor the implementation of the corrective action plan.

(Rule 1200-8-6-.11, continued)

- (e) The department shall approve in writing, the corrective action report if the department is satisfied that the corrective action plan appropriately addresses errors that contributed to the unusual event and takes the necessary steps to prevent the recurrence of the errors. If the department fails to approve the corrective action report, then the department shall provide the facility with a list of actions that the department believes are necessary to address the errors. The facility shall be offered an informal meeting with the Commissioner or the Commissioner's representative to attempt to resolve any disagreement over the corrective action report. If the department and the facility fail to agree on an appropriate corrective action plan, then the final determination on the adequacy of the corrective action report shall be made by the Board after a contested case hearing.
- (f) The event report reviewed or obtained by the department shall be confidential and not subject to discovery, subpoena or legal compulsion for release to any person or entity, nor shall the report be admissible in any civil or administrative proceeding other than a disciplinary proceeding by the department or the appropriate regulatory board. The report is not discoverable or admissible in any civil or administrative action except that information in any such report may be transmitted to an appropriate regulatory agency having jurisdiction for disciplinary or license sanctions against the impacted facility. The department must reveal upon request its awareness that a specific event or incident has been reported.
- (g) The department shall have access to facility records as allowed in Title 68, Chapter 11, Part 3. The department may copy any portion of a facility medical record relating to the reported event unless otherwise prohibited by rule or statute. This section does not change or affect the privilege and confidentiality provided by T.C.A. §63-6-219.
- (h) The department, in developing the unusual event report form, shall establish an event occurrence code that categorizes events or specific incidents by the examples set forth above in (a) and (b). If an event or specific incident fails to come within these examples, it shall be classified as "other" with the facility explaining the facts related to the event or incident.
- (i) This does not preclude the department from using information obtained under these rules in a disciplinary action commenced against a facility, or from taking a disciplinary action against a facility. Nor does this preclude the department from sharing such information with any appropriate governmental agency charged by federal or state law with regulatory oversight of the facility. However, all such information must at all times be maintained as confidential and not available to the public. Failure to report an unusual event, submit a corrective action report, or comply with a plan of correction as required herein may be grounds for disciplinary action pursuant to T.C.A. §68-11-207.
- (j) The affected patient and/or the patient's family, as may be appropriate, shall also be notified of the event or incident by the facility.
- (k) During the second quarter of each year, the Department shall provide the Board an aggregate report summarizing by type the number of unusual events and incidents reported by facilities to the Department for the preceding calendar year.
- (l) The Department shall work with representatives of facilities subject to these rules, and other interested parties, to develop recommendations to improve the collection and assimilation of specific aggregate health care data that, if known, would track health care trends over time and identify system-wide problems for broader quality improvement. The goal of such recommendations should be to better coordinate the collection of such data, to analyze the data, to identify potential problems and to work with facilities to develop best practices to remedy identified problems. The Department shall prepare and issue a report regarding such recommendations.

(Rule 1200-8-6-.11, continued)

- (3) The nursing home shall retain legible copies of the following records and reports for thirty-six months following their issuance. They shall be maintained in a single file and shall be made available for inspection during normal business hours to any person who requests to view them:
  - (a) Local fire safety inspections;
  - (b) Local building code inspections, if any;
  - (c) Fire marshal reports;
  - (d) Department licensure and fire safety inspections and surveys;
  - (e) Federal Health Care Financing Administration surveys and inspections, if any;
  - (f) Orders of the Commissioner or Board, if any;
  - (g) Comptroller of the Treasury's audit reports and findings, if any; and,
  - (h) Maintenance records of all safety equipment.
- (4) A yearly statistical report, the "Joint Annual Report of Nursing Homes", shall be submitted to the Department. The forms are mailed to each nursing home by the Department each year. The forms shall be completed and returned to the Department as requested.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, and 68-11-804. **Administrative History:** Original rule filed March 27, 1975; effective April 25, 1997. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Amendment filed March 13, 1986; effective April 12, 1986. Amendment filed December 29, 1993; effective February 15, 1993. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed September 4, 2003; effective November 18, 2003.

#### **1200-8-6-.12 RESIDENT RIGHTS.**

- (1) The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Residents and their families or other representatives shall be fully informed and documentation shall be maintained in the resident's file of the following rights:
  - (a) To privacy in treatment and personal care;
  - (b) To privacy, if married, for visits by his/her spouse;
  - (c) To share a room with his/her spouse (if both are residents);
  - (d) To be different, in order to promote social, religious and psychological well being;
  - (e) To privately talk and/or meet with and see anyone;
  - (f) To send and receive mail promptly and unopened;
  - (g) To be free from mental and physical abuse. Should this right be violated, the facility must notify the department within five (5) working days. The Tennessee Department of Human Services, Adult Protective Services shall be notified immediately as required in T.C.A. §71-6-103;

(Rule 1200-8-6-.12, continued)

- (h) To be free from chemical and physical restraints;
- (i) To meet with members of and take part in activities of social, commercial, religious and community groups. The administrator may refuse access to the facility to any person if that person's presence would be injurious to the health and safety of a resident or staff, or would threaten the security of the property of the resident, staff or facility;
- (j) To form and attend resident council meetings. The facility shall provide space for meetings and reasonable assistance to the council when requested;
- (k) To retain and use personal clothing and possessions as space permits;
- (l) To be free from being required by the facility to work or perform services;
- (m) To be fully informed by a physician of his/her health and medical condition. The facility shall give the resident and family the opportunity to participate in planning the resident's care and medical treatment;
- (n) To refuse treatment. The resident must be informed of the consequences of that decision. The refusal and its reason must be reported to the physician and documented in the medical record;
- (o) To refuse experimental treatment and drugs. The resident's written consent for participation in research must be obtained and retained in the medical record;
- (p) To have records kept confidential and private. Written consent by the resident must be obtained prior to release of information except to persons authorized by law. If the resident is mentally incompetent, written consent is required from the resident's legal representative. The nursing home must have policies to govern access and duplication of the resident's record;
- (q) To manage personal financial affairs. Any request by the resident for assistance must be in writing. A request for any additional person to have access to a resident's funds must also be in writing;
- (r) To be told in writing before or at the time of admission about the services available in the facility and about any extra charges, charges for services not covered under Medicare or Medicaid, or not included in the facility's bill;
- (s) To be free from discrimination because of the exercise of the right to speak and voice complaints;
- (t) To exercise his/her own independent judgment by executing any documents, including admission forms;
- (u) To have a free choice of providers of medical services, such as physician and pharmacy. However, medications must be supplied in packaging consistent with the medication system of the nursing home;
- (v) To be free from involuntary transfer or discharge, except for these reasons:
  - 1. Medical reasons;
  - 2. His/her welfare or that of the other residents; or
  - 3. Nonpayment, except as prohibited by the Medicaid program;

(Rule 1200-8-6-.12, continued)

- (w) To voice grievances and complaints, and to recommend changes in policies and services to the facility staff or outside representatives of the resident's choice. The facility shall establish a grievance procedure and fully inform all residents and family members or other representatives of the procedure;
  - (x) To have appropriate assessment and management of pain; and
  - (y) To be involved in the decision making of all aspects of their care.
- (2) The rights set forth in this section may be abridged, restricted, limited or amended only as follows:
- (a) When medically contraindicated;
  - (b) When necessary to protect and preserve the rights of other residents in the facility; or
  - (c) When contradicted by the explicit provisions of another rule of the board.
- (3) Any reduction in residents' rights based upon medical consideration or the rights of other residents must be explicit, reasonable, appropriate to the justification, and the least restrictive response feasible. They may be time-limited, shall be explained to the resident, and must be documented in the individual resident's record by reciting the limitation's reason and scope. Medical contraindications shall be supported by a physician's order. At least once each month, the administrator and the director of nursing shall review the restriction's justification and scope before removing it, amending it, or renewing it. The names of any residents in the facility whose rights have been restricted under the provisions of this rule shall be maintained on a separate list which shall be available for inspection by the department and by the area long-term care ombudsman.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-901, and 68-11-902.  
**Administrative History:** Original rule filed March 27, 1975; effective April 25, 1975. Repeal and new rule filed July 14, 1983; effective August 15, 1983. Amendment filed May 24, 1985; effective June 23, 1985. Amendment filed March 13, 1986; effective April 12, 1986. Amendment filed October 22, 1987; effective December 6, 1987. Amendment filed May 10, 1990; effective June 24, 1990. Amendment filed March 9, 1992; effective April 23, 1992. Amendment filed March 10, 1995; effective May 24, 1995. Amendment filed June 13, 1997; effective August 27, 1997. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed June 18, 2002; effective September 1, 2002.

#### **1200-8-6-.13 POLICIES AND PROCEDURES FOR HEALTH CARE DECISION-MAKING FOR INCOMPETENT RESIDENTS.**

- (1) Pursuant to this Rule, each nursing home shall maintain and establish policies and procedures governing the designation of a health care decision-maker for making health care decisions for a resident who is incompetent or who lacks decision-making capacity, including but not limited to allowing the withholding of CPR measures from individual residents. The policies and procedures for determining when resuscitative services may be withheld must respect the resident's rights of self-determination. The nursing home must inform the resident and/or the resident's health care decision-maker of these policies and procedures upon admission or at such time as may be appropriate.
- (2) The nursing home should identify, after consultation with the family or responsible party, the name of the health care decision-maker for a resident who is incompetent or who lacks decision-making capacity, who will be responsible, along with the treating physician, for making health care decisions, including but not limited to deciding on the issuance of a DNR order.
- (3) Health care decisions made by a health care decision-maker must be made in accord with the resident's individual health care instructions, if any, and other wishes to the extent known to the health care decision-maker. If the resident's specific wishes are not known, decisions are to be made in accord

(Rule 1200-8-6-.13, continued)

with the health care decision-maker's determination of the resident's desires or best interests in light of the personal values and beliefs of the resident to the extent they are known.

- (4) In the case of a resident who lacks decision-making capacity and who has not appointed an individual to act on his or her behalf pursuant to an advance directive and who does not have a court-appointed guardian or conservator with health care decision-making authority, documentation in the medical record must identify the resident's surrogate to make health care decisions on the resident's behalf.
  - (a) The resident's surrogate shall be an adult who:
    1. has exhibited special care and concern for the resident, who is familiar with the resident's personal values, and who is reasonably available; and
    2. consideration shall if possible be given in order of descending preference for service as a surrogate to:
      - (i) the resident's spouse,
      - (ii) the resident's adult child,
      - (iii) the resident's parent,
      - (iv) the resident's adult sibling,
      - (v) any other adult relative of the resident, or
      - (vi) any other adult who satisfies the requirement under part 1 above.
  - (b) If none of the individuals eligible to act as a surrogate under subparagraph (a), is reasonably available, the resident's treating physician may make health care decisions for the resident after the treating physician either (i) consults with and obtains the recommendations of an institutional ethics committee, or (ii) consults with a second physician who (A) is not directly involved in the resident's health care; (B) either (i) does not serve in a capacity of decision-making or influence or responsibility over the treating physician, or (ii) for whom the treating physician does not exert decision-making, influence or responsibility; and (C) concurs with the treating physician's decision. For the purposes of this rule, "institutional ethics committee" means a committee of a licensed health care institution which renders advice concerning ethical issues involving health care.
- (5) All residents shall be presumed as having consented to CPR unless there is documentation in the medical record that the resident has specified that a DNR order be written. DNR orders may be written to exclude any portion of the CPR measures deemed to be unacceptable.
- (6) In the case of an incompetent resident who has appointed an attorney in fact to act on his or her behalf pursuant to an advance directive or who has a court-appointed guardian or conservator with health care decision-making authority, documentation in the medical record must reflect that the attorney in fact, guardian or conservator has specified that a DNR order be written. In the case of a resident who lacks decision-making capacity and who has not appointed an individual to act on his or her behalf pursuant to an advance directive and who does not have a court-appointed guardian or conservator with health care decision-making authority, documentation in the medical record must identify the resident's surrogate to make health care decisions on the resident's behalf, and reflect that the resident's surrogate and the resident's treating physician have mutually specified that a DNR order be written.

(Rule 1200-8-6-.13, continued)

- (7) CPR may be withheld from the resident if in the judgment of the treating physician an attempt to resuscitate would be medically futile. Withholding and withdrawal of resuscitative services shall be regarded as identical for the purposes of these regulations.
- (8) Procedures for periodic review of DNR orders must be established and maintained. The nursing home must have procedures for allowing revocation or amending DNR orders by the resident, the resident's health care decision-maker, or treating physician. Such change shall be documented in the medical record.
- (9) Any treating physician who refuses to enter a DNR order in accordance with provisions set forth above, or to comply with a DNR order, shall promptly advise the resident or the resident's health care decision-maker of this decision. The treating physician shall then:
  - (a) Make a good faith attempt to transfer the resident to another physician who will honor the DNR order; and,
  - (b) Permit the resident to obtain another physician.
- (10) Each nursing home shall establish, and set forth in writing, a mediation process to deal with any dispute regarding health care decisions, including DNR orders, or the determination of the health care decision-maker.
- (11) This rule does not alter any requirements imposed by state or federal law, where applicable, including Title 33, the mental health and developmental disabilities law.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-224.  
**Administrative History:** Original rule filed June 22, 1992; effective August 6, 1992. Repeal and new rule filed January 31, 2000; effective April 15, 2000. Amendment filed April 28, 2003; effective July 12, 2003.

#### **1200-8-6-.14 DISASTER PREPAREDNESS.**

- (1) Emergency Electrical Power.
  - (a) All nursing homes must have one or more on-site electrical generators which are capable of providing emergency electrical power to at least all life sustaining equipment and life sustaining resources such as: ventilators, blood banks, biological refrigerators, safety switches for boilers, safety lighting for corridors and stairwells, and other essential equipment.
  - (b) Connections shall be through a switch which shall automatically transfer the circuits to the emergency power source in case of power failure. It is recognized that some equipment may not sustain automatic transfer and provisions will have to be made to manually change these items from a non-emergency powered outlet to an emergency powered outlet or other power source. All emergency power transfer switches shall be labeled as such. Switches affecting heat, ventilation, and all systems shall be labeled.
  - (c) The emergency power system shall have a minimum of twenty four (24) hours of either propane, gasoline or diesel fuel. The quantity shall be based on its expected or known connected load consumption during power interruptions. In addition, the nursing home shall have a written contract with an area fuel distributor which guarantees first priority service for re-fills during power interruptions.
  - (d) The emergency power system (generator) shall be inspected weekly and exercised under actual load and operating temperature conditions for at least thirty (30) minutes, once each month, including automatic and manual transfer of equipment. The generator shall be exercised by trained facility staff who are familiar with the systems operation. Instructions for the operation

(Rule 1200-8-6-.14, continued)

of the systems and the manual transfer of emergency power shall be maintained with the facility's disaster preparedness plan and shall be separately identified in the plan. Records shall be maintained for all weekly inspections and monthly tests and be kept on file for a minimum of three (3) years.

(2) Physical Facility and Community Emergency Plans.

(a) Physical Facility (Internal Situations).

1. Every nursing home shall have a current internal emergency plan, or plans, that provides for fires, bomb threats, severe weather, utility service failures, plus any local high risk situations such as floods, earthquakes, toxic fumes and chemical spills. The plan should consider the probability of the types of disasters which might occur, both natural and "man-made".
2. The plan(s) must include provisions for the relocation of persons within the building and/or either partial or full building evacuation. Facilities which do not have sufficient emergency generator capacity to provide a place of refuge for residents during severe hot or cold weather emergencies shall specifically establish an emergency plan to assure a common area (dining room, hallway, or day rooms) is heated or cooled sufficiently to sustain residents during an emergency. This can be accomplished through several approaches including the installation of a transfer switch at the facility to which an emergency generator may be connected to operate a HVAC system for the place of refuge, or transportation of a generator to the facility and direct connection from the generator to emergency portable heating or cooling units. The plan must be coordinated with local emergency management agencies that provide emergency generators or heating or cooling units; and facilities are encouraged to enter into private agreements with local generator suppliers, rental agencies or other reliable sources of emergency power. Plans that provide for the relocation of residents to other health care facilities must have written agreements for emergency transfers. The agreements may be mutual, i.e. providing for transfers either way.
3. Copies of the plan(s), either complete or outlines, including specific emergency telephone numbers related to that type of disaster, shall be available to all staff. A copy shall be readily available at all times in the telephone operator's position or at the security center. Provisions that have security implications may be omitted from the outline versions. Familiarization information shall be included in employee orientation sessions and more detailed instructions must be included in continuing education programs. Records of orientation and education programs must be maintained for at least three (3) years.
4. The plan must provide for additional staffing, medical supplies, blood and other resources which would probably be needed.
5. Each of the following disaster preparedness plans shall be conducted annually prior to the month listed in the plan. Drills are for the purpose of educating staff, resource determination, testing personnel safety provisions and communications with other facilities and community agencies. Records which document and evaluate these drills must be maintained for at least three (3) years.
  - (i) Fire Safety Procedures Plan, to be exercised at any time during the year, shall include:
    - (I) Minor fires;
    - (II) Major fires;

(Rule 1200-8-6-.14, continued)

- (III) Fighting the fire;
  - (IV) Evacuation procedures;
  - (V) Staff functions by department and job assignment; and,
  - (VI) Fire drill schedules (fire drills shall be held at least quarterly on each work shift).
- (ii) External disaster procedures plan (for tornado, flood, earthquake), to be exercised prior to March, shall include:
    - (I) Staff duties by department and job assignment; and,
    - (II) Evacuation procedures.
  - (iii) Bomb Threat Procedures Plan, to be exercised at any time during the year:
    - (I) Staff duties by department and job assignment; and,
    - (II) Search team, searching the premises.
6. The nursing home shall develop and periodically review with all employees a prearranged plan for the orderly evacuation of all residents in case of a fire, internal disaster or other emergency. The plan of evacuation shall be posted throughout the home. Fire drills shall be held at least quarterly for each work shift for nursing home personnel in each separate patient-occupied nursing home building. There shall be a written report documenting the evaluation of each drill and the action recommended or taken for any deficiencies found. Records which document and evaluate these drills must be maintained for at least three (3) years.
7. All fires which result in a response by the local fire department shall be reported to the department within five (5) business days. The report shall contain sufficient information to ascertain the nature and location of the fire, its probable cause and any injuries incurred by any person or persons as a result of the fire. Initial reports by the nursing home may omit the name(s) of resident(s) and other parties involved; however, should the department find the identities of such persons to be necessary to an investigation, the nursing home shall provide such information.
- (b) Community Emergency (Mass Casualty).
- 1. Every nursing home, unless exempted due to its limited scope of clinical services, shall have a plan that provides for the reception and treatment, within its capabilities, of medical emergencies resulting from a disaster within its usual service area. The plan should consider the probability of the types of disasters which might occur, both natural and "man-made".
  - 2. The plan must provide for additional staffing, medical supplies, blood and other resources which would probably be needed. The plan must also provide for the deferral of elective admission patients and also for the early transfer or discharge of some current patients if it appears that the number of casualties will exceed available staffed beds.
  - 3. Copies of the plan(s), either complete or outlines, including specific emergency telephone numbers related to that type of disaster, shall be available to staff who would be assigned

(Rule 1200-8-6-.14, continued)

non-routine duties during these types of emergencies. Familiarization information shall be included in employee orientation sessions and more detailed instruction must be included in continuing education programs. Records of orientation and education must be maintained for at least three (3) years.

4. At least one drill shall be conducted each year for the purpose of educating staff, resource determination, and communications with other facilities and community agencies. Records which document and evaluate these drills must be maintained for at least three (3) years.
5. As soon as possible, actual community emergency situations that result in the treatment of more than twenty (20) patients, or fifteen percent (15%) of the licensed bed capacity, whichever is less, must be documented. Actual situations that had education and training value may be substituted for a drill. This includes documented actual plan activation during community emergencies, even if no patients are received.

(c) Emergency Planning with Local Government Authorities.

1. All nursing homes shall establish and maintain communications with the county Emergency Management Agency. This includes the provision of the information and procedures that are needed for the local comprehensive emergency plan. The facility shall cooperate, to the extent possible, in area disaster drills and local emergency situations.
2. Each nursing home must rehearse both the Physical Facility and Community Emergency plan as required in this rule, even if the local Emergency Management Agency is unable to participate.
3. A file of documents demonstrating communications and cooperation with the local agency must be maintained.

**Authority:** T.C.A. §§4-5-202, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-216. **Administrative History:** Original rule filed February 9, 1998; effective April 25, 1998. Repeal and new rule filed January 31, 2000; effective April 15, 2000.

**1200-8-6-.15 NURSE AIDE TRAINING AND COMPETENCY EVALUATION.** All nurse aide training programs must comply with the federal nurse aide training and competency regulations, promulgated pursuant to the Omnibus Budget Reconciliation Act of 1987, and with federal labor laws, including but not limited to minimum age requirements. Copies of these regulations may be obtained from the department.

(1) Testing service.

- (a) The Department shall provide or contract for the provision of nurse aide testing services as follows:
  1. Annual publication of testing schedules and sites.
  2. Test sites shall be located so that no individual is required to drive farther than thirty (30) miles to reach a test site.
  3. Scheduled tests shall be administered, except when no individual is scheduled to test at a particular test site.
  4. The number of individuals passing and failing shall be published following each test.

(Rule 1200-8-6-.15, continued)

5. The minimum passing grade for each test shall be seventy-five percent (75%) for the written or oral component. The performance demonstration portion of the test shall consist, at minimum, of five performance tasks, which shall be selected randomly for each registrant from a pool of skills evaluation tasks ranked according to degree of difficulty, with at least one task selected from each degree of difficulty. Registrants are required to pass a minimum of five (5) performance tasks.
  6. Individuals who fail any portion of the test three (3) consecutive times shall repeat training prior to taking the test again.
- (b) Applications to take the test shall be sent by the program coordinator to the appropriate testing agency postmarked no later than thirty (30) days prior to the test date. Requests for special testing needs shall be made to the testing agency at this time.
  - (c) The department shall provide the board with quarterly reports on the number of individuals passing and failing each test.
  - (d) A practical and written test will be developed to reflect that a trainee has acquired the minimum competency skills necessary to become a competent and qualified nurse aide. The Nurse Aide Advisory Committee, composed of twelve (12) members with at least three (3) members nominated by the Tennessee Health Care Association, will periodically review testing materials and set criteria for survey visits of the nurse aide programs.
  - (e) The test will be developed from a pool of questions, only a portion of which is to be used for grading purposes in any one test, not to exceed one hundred (100) questions. A system must be developed which prevents the disclosure of the pool of questions and of the performance demonstration portion of the test.
- (2) Training program.
    - (a) Requests for approval of a nurse aide training program shall be submitted to the department and shall include the following:
      1. Name, address and telephone number of the facility, institution or agency offering the program;
      2. The program coordinator's name, address, license number and verification of a minimum of two (2) years nursing experience, at least one of which must be in the provision of long-term care facility services;
      3. Statement of course objectives;
      4. Description of course content specifying the number of hours to be spent in the classroom and in clinical settings; and,
      5. In lieu of (3) and (4) above, the fact that the curriculum is previously department-approved.
    - (b) Notification of any change to any one of the above five (5) items or termination of the program must be submitted to the department within 30 days.
    - (c) Each training program shall have a pass rate on both written and performance exams of at least 70%. Annual reviews of Nurse Aide Training Programs shall include:
      1. Letter of commendation for exceptional pass rate as evaluated by the department;

(Rule 1200-8-6-.15, continued)

2. Letter of concern for programs having one year of test pass rates below 70%;
  3. Request for plan of program improvement for programs with two consecutive years of test pass rates below 70%;
  4. Request to appear before the Board for programs with two consecutive years of test pass rates below 70%; and
  5. Program is subject to closure after demonstration of a consistent pattern of poor test performance.
- (d) Each program coordinator shall be responsible for ensuring that the following requirements are met:
1. Course objectives are accomplished;
  2. Only persons having appropriate skills and knowledge are selected to conduct any part of the training;
  3. The provision of direct individual care to residents by a trainee is limited to appropriately supervised clinical experiences; a program instructor must be present or readily available on-site during all clinical training hours including direct patient care for the seventy-five (75) hour training program. All activities of daily living (ADL) skills, including but not limited to bathing, feeding, toileting, grooming, oral care, and perineal care, must be taught prior to student performing direct patient care;
  4. The area used for training is well-lighted, well-ventilated and provides for privacy for instruction. Such requirements are not to exceed the requirements for physical space in a nursing facility;
  5. Each trainee demonstrates competence in clinical skills and fundamental principles of resident care;
  6. Records are kept to verify the participation and performance of each trainee in each phase of the training program. The satisfactory completion of the training program by each trainee shall be attested to on each trainee's record;
  7. Each trainee is issued a certificate of completion which includes at least the name of the program, the date of issuance, the trainee's name and the signature of the program coordinator.
  8. The program coordinator shall be responsible for the completion, signing and submission to the department of all required documentation.
- (e) Student to teacher ratio must be as follows: 25:1 in classroom and 15:1 for direct patient care training.
- (3) Nurse Aide Registry. A nursing home must not use any individual working in a facility as a nurse aide for more than four (4) months unless that individual's name is included on the Nurse Aide Registry. A facility must not use on a temporary, per diem, leased or any basis other than permanent, any individual who does not meet the requirements of training and competency testing.
- (a) The nurse aide registry shall include:

(Rule 1200-8-6-.15, continued)

1. The individual's full name, including a maiden name and any other surnames used;
  2. The individual's last known home address;
  3. The individual's date of birth; and,
  4. The date that the individual passed the competency test and the expiration date of the individual's current registration.
- (b) The name of any individual who has not performed nursing or nursing related services for a period of twenty-four (24) consecutive months shall be removed from the Nurse Aide Registry.
- (4) Continued Competency. The facility must complete a performance review of each nurse aide employee at least once every 12 months and must provide regular in-service education based on the outcome of these reviews.

**Authority:** T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, and 68-11-804. **Administrative History:** Original rule filed September 4, 2003; effective November 18, 2003.