STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

NURSING HOME ADMINISTRATOR
PUBLIC HEALTH CODE

CONTENTS

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19-13-D8t. Chronic and convalescent nursing homes and rest homes with nursing supervision

(a) Definitions. As used in this subsection:

(1) "Attending physician" means the physician attending the patient at the time of treatment;

(2) "By-Laws" means a set of rules adopted by the facility for governing its operation;

(3) "Certified Nurse's Aide" means a nurse's aide issued a certificate - from January 1, 1982 through January 31, 1990 - of satisfactory completion of a training program which has been approved by the department;

(4) "Commissioner" means the Commissioner of the Connecticut Department of Health Services;

(5) "Curriculum" means the plan of classroom and clinical instructions for training and skills assessment leading to registration as a nurse's aide, which has been approved by the commissioner;

(6) "Department" means the Connecticut Department of Health Services;

(7) "Facility" means a chronic and convalescent nursing home and/or a rest home with nursing supervision;

(8) "Full time" means a time period of not less than 32 hours, established as a full working week by a facility;

(9) "Job description" means a written list developed for each position in the facility, containing the qualifications, duties, responsibilities, and accountability required of all employees in that position;

(10) "Licensed nursing personnel" means registered nurses or licensed practical nurses licensed in Connecticut;

(11) "Nurse’s aide” means an individual providing nursing or nursing-related services to residents in a chronic and convalescent nursing home or rest home with nursing supervision, but does not include an individual who is a health professional otherwise licensed or certified by the Department of Public Health, or who volunteers to provide such services without monetary compensation.

(12) "Patient care plan" means an overall, interdisciplinary written plan documenting an evaluation of the individual patient's needs, short and long term goals, and care and treatment;

(13) "Personal physician" means the physician indicated on the patient's medical record as being responsible for the medical care of that patient;

(14) "Reportable Event" means a happening, occurrence, situation or circumstance which was unusual or inconsistent with the policies and practices of the facility;

(15) "Supervision" means the direction, inspection, and on-site observation of the functions and activities of others in the performance of their duties and responsibilities;

(16) "Therapeutic recreation" means individual and group activities designed to improve the physical and mental health and condition of each patient.

(b) Licensure procedure.

(1) Commission on hospitals and health care. A facility shall not be constructed, expanded or licensed to operate except upon application for, receipt of, and compliance with all limitations and conditions required by the commission on hospitals and health care in accordance with Connecticut General Statutes, Sections 19-73l through 19-73n inclusive.

(2) Application for licensure.

(A) No person shall operate a facility without a license issued by the department in accordance with the Connecticut General Statutes, sections 19-576 through 19-586 inclusive.

(B) Application for the grant or renewal of a license to operate a facility shall be made in writing on forms provided by the department; shall be signed by the person seeking authority to operate the facility; shall be notarized; and shall include the following information if applicable:

(i) Application for Owner's Certificate of Compliance, as required by subsection (v) (1) of these regulations;
(ii) Names and titles of professional and nurse's aide staff;
(iii) Upon initial appointment only, signed acknowledgement of duties for the administrator, medical director, and director of nurses;
(iv) Patient capacity;
(v) Total number of employees, by category;
(vi) Services provided;
(vii) Evidence of financial capacity;
(viii) Certificates of malpractice and public liability insurance;
(ix) Local Fire Marshal's annual certificate.

(3) Issuance and renewal of license.

(A) Upon determination by the department that a facility is in compliance with the statutes and regulations pertaining to its licensure, the department shall issue a license or renewal of license to operate the facility for a period not to exceed one year.

(a) Each building which is not physically connected to a licensed facility shall be treated as a distinct facility for purposes of licensure;
(ii) A facility which contains more than one level of care within a single building shall be treated as a single facility for purposes of licensure;

(B) A license shall be issued in the name of the person who signs the application for the license for a specific facility. The license shall not be transferable to any other person or facility.

(C) Each license shall specify the maximum licensed bed capacity for each level of care, and shall list on its face the names of the administrator, medical director, and director of nurses, and notations as to waivers of any provision of this code. No facility shall have more patients than the number of beds for which it is licensed.

(4) Notice to public. The license shall be posted in a conspicuous place in the lobby by reception room of the facility.

(5) Change in status. Change of ownership, level of care, number of beds or location shall require a new license to be issued. The licensee shall notify the department in writing no later than 90 days prior to any such proposed change.

(6) Change in personnel. The licensee shall notify the department immediately, to be confirmed in writing within five days, of both the resignation or removal and the subsequent appointment of the facility's administrator, medical director, or director of nurses.

(7) Failure to grant the department access to the facility or to the facility's records shall be grounds for denial or revocation of the facility's license.

(8) Surrender of license. The facility shall directly notify each patient concerned, the next of kin and/or guardian, the patient's personal physician, and any third party payors concerned at least 30 days prior to the voluntary surrender of the facility's license or surrender of license upon the department's order of revocation, refusal to renew or suspension of license. In such cases, the license shall be surrendered to the department within seven days of the termination of operation.

(c) Waiver.

(1) The commissioner or his/her designee, in accordance with the general purpose and intent of these regulations, may waive provisions of these regulations if the commissioner determines that such waiver would not endanger the life, safety or health of any patient. The commissioner shall have the power to impose conditions which assure the health, safety and welfare of patients upon the grant of such waiver, or to revoke such waiver upon a finding that the health, safety, or welfare of any patient has been jeopardized.

(2) Any facility requesting a waiver shall apply in writing to the department. Such application shall include:
- (A) The specific regulations for which the waiver is requested;
- (B) Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the facility upon enforcement of the regulations;
- (C) The specific relief requested; and
- (D) Any documentation which supports the application for waiver.

(3) In consideration of any application for waiver, the commissioner or his/her designee may consider the following:
- (A) The level of care provided;
- (B) The maximum patient capacity;
- (C) The impact of a waiver on care provided;
- (D) Alternative policies or procedures proposed.

(4) The Department reserves the right to request additional information before processing an application for waiver.

(5) Any hearing which may be held in conjunction with an application for waiver shall be held in conformance with Chapter 54 of the Connecticut General Statutes and department regulations.

(d) General Conditions.

(1) Patient admission.
- (A) Patients shall be admitted to the facility only after a physician certifies the following:
  - (b) That a patient admitted to a chronic and convalescent nursing home has uncontrolled and/or unstable and/or chronic conditions requiring continuous skilled nursing services and/or nursing supervision or has chronic conditions requiring substantial assistance with personal care, on a daily basis;
  - (ii) That a patient admitted to a rest home with nursing supervision has controlled and/or stable chronic conditions which require minimal skilled nursing services, nursing supervision, or assistance with personal care on a daily basis.
- (B) Nothing in subparagraph (A) above shall require the transfer of any patient admitted to the facility prior to October 1, 1981.
- (C) No patient shall be admitted to a facility without compliance with the above requirements except in the event of an emergency, in which case the facility shall notify the Department within 72 hours after such admission.

(2) Visiting hours shall be as liberal as is consistent with good patient care but shall in no event be less than eight hours per day.

(3) Patient Identification.
- (A) Each chronic and convalescent nursing home shall ensure that all patients wear, at all times, identification bracelets or some other form of visible identification.
- (B) A method for identification of all patients at all times shall be established by rest homes with nursing supervision.

(4) All areas used by patients shall have temperatures of not less than 75° F. All other occupied areas shall have temperatures of not less than 70° F.

(5) When a patient ceases to breathe and has no detectable pulse or blood pressure, the patient shall be screened from view of other patients. Upon pronouncement of death in accordance with Section 7-62b of the Connecticut General Statutes or Sections 7-62-1 through 7-62-3 of the Regulations of Connecticut State Agencies, the body shall be moved promptly to the facility's holding room, as required by subsection (v) (13) (B) of these regulations.

(6) All medications shall be administered only by licensed nursing personnel, qualified physician assistants or other health care practitioners with statutory authority to administer medications and/or in accordance with Section 19-13-D8v (b) (5) (B) of the Regulations of Connecticut State Agencies.

(e) Governing body.

(1) The facility shall have a governing body, which shall have the general responsibilities to:

(A) set policy;

(B) oversee the management and operation of the facility; and

(C) assure the financial viability of the facility.

(2) Specific responsibilities of the governing body necessary to carry out its general responsibilities shall include, but not necessarily be limited to, the following:

(A) adoption and documented annual review of written facility by-laws and budget;

(B) annual review and update of the facility's institutional plan, including anticipated needs, income and expenses;

(C) review of facility compliance with established policy;

(D) appointment of a qualified administrator;

(E) provision of a safe physical plant equipped and staffed to maintain the facility and services in accordance with any applicable local and state regulations and any federal regulations that may apply to federal programs in which the facility participates;

(F) approval of an organizational chart which establishes clear lines of responsibility and authority in all matters relating to management and maintenance of the facility and patient care;

(G) annual review of personnel policies;

(H) adoption of written policies assuring the protection of patients' rights and patient grievance procedures, a description of which shall be posted conspicuously in the facility and distributed personally to each patient;

(I) determination of the frequency of meetings of the governing body and documentation of such meetings through minutes;

(J) written confirmation of all appointments made or approved by the governing body; and

(K) adoption of a written policy concerning potential conflict of interest on the part of members of the governing body, the administration, medical and nursing staff and other employees who might influence corporate decisions.

(f) Administrator.

(1) The administrator of any facility shall be licensed in accordance with Connecticut General Statutes, sections 19-593 through 19-599 inclusive.

(2) Application for licensure. The following shall be submitted with the administrator's initial application for licensure:

(A) Three references evaluating his/her suitability to administer a facility, as follows:

(i) One from a nursing home administrator, licensed physician, or registered nurse, attesting to the applicant's professional qualifications and degree of experience;

(ii) Two character references from persons not related to the applicant;

(B) A certificate of physical and mental health signed by a licensed physician.
(C) Educational background.

(3) The administrator shall be responsible for the overall management of the facility and shall have the following powers and responsibilities:
(A) Enforcement of any applicable local and state regulations, any federal regulations that may apply to federal programs in which the facility participates, and facility by-laws;
(B) Appointment, with the approval of the governing body, of a qualified medical director and director of nurses and, if required, an assistant director of nurses;
(C) Liaison between the governing body, medical and nursing staff, and other professional and supervisory staff;
(D) Protection of patients' personal and property rights;
(E) Appointment, in writing and with the approval of the governing body, of a responsible employee to act in his/her behalf in temporary absences;
(F) With the advice of the medical director and director of nurses, employment of qualified personnel in sufficient numbers to assess and meet patient needs;
(G) Written definition of the duties and responsibilities of all personnel classifications;
(H) Maintenance of a patient roster and annual census of all patients admitted and/or discharged by the facility. Such census shall be submitted to the department no later than October 31 for each year ending September 30;
(I) Submission to the department of the facility's annual license application and required reports, including, but not limited to, submission within 72 hours of reports on all accidents, or incidents, and any unusual or suspicious deaths in connection with subsection (g) of these regulations;
(J) Together with the medical director and director of nurses, development of a coordinated program for orientation to the facility, in-service training, and continuing education for all categories of staff in order to develop skills and increase knowledge so as to improve patient care;
(K) Establishment of procedures for notification of the patient, next of kin or sponsor in the event of a change in a patient's charges, billing status and other related matters.

(4) In a chronic and convalescent nursing home with 45 or more licensed beds, the administrator shall serve full time on the premises of the facility and shall be on 24 hour call.

(5) In a rest home with nursing supervision with 60 or more licensed beds, the administrator shall serve full time on the premises of the facility, and shall be on 24 hour call.

(6) Except for a facility with 29 beds or less, the administrator may not serve as director of nurses.

(g) Reportable event(s)

(1) Classification. All reportable events shall be classified as follows:

Class A: an event that has caused or resulted in a patient's death or presents an immediate danger of death or serious harm;

Class B: an event that indicates an outbreak of disease or foodborne outbreaks as defined in section 19a-36-A1 of the Regulations of Connecticut State Agencies; a complaint of patient abuse or an event that involves an abusive act to a patient by any person; for the purpose of this classification, abuse means a verbal, mental, sexual, or physical attack on a patient that may include the infliction of injury, unreasonable confinement, intimidation, or punishment;

Class C: an event (including but not limited to loss of emergency electrical generator power, loss of heat, loss of water system) that will result in the evacuation of one (1) or more patients within or outside of the facility and all fires regardless of whether services are disrupted;

Class D: an event that has caused or resulted in a serious injury or significant change in a patient's condition, an event that involves medication error(s) of clinical significance, or an adverse drug reaction of clinical significance which for the purpose of this classification, shall mean an event that adversely alters a patient's mental or physical condition, or

Class E: an event that has caused, or resulted in minor injury, distress or discomfort to a patient.

(2) All reportable events shall be documented in a format required by the Department. All documentation of reportable events shall be maintained at the facility for not less than three (3) years.

(3) Report. The licensed administrator or his/her designee shall report any reportable event to the Department as follows:

Classes A, B and C: immediate notice by telephone to the Department, to be confirmed by written report as provided herein within seventy-two (72) hours of said event;

Class D: written report to the Department as provided herein within seventy-two (72) hours of said event; and

Class E: written report of event at time of occurrence or discovery shall be maintained on file at the facility for review by the Department.

(4) Each written report required by subdivision (3) of this subsection shall contain the following information:

(A) date of report and date of event;

(B) licensed level of care and bed capacity of the facility;

(C) identification of the patient(s) affected by the event including:

i. name;

ii. age;

iii. injury;

iv. distress or discomfort;

v. disposition;

vi. date of admission;

vii. current diagnosis;

viii. physical and mental status prior to the event; and

ix. physical and mental status after the event;

(D) the location, nature and brief description of the event;

(E) the name of the physician consulted, if any, and time of notification of the physician and a report summarizing any subsequent physical examination, including findings and orders;

(F) the names of any witnesses to the event;

(G) any other information deemed relevant by the reporting authority or the licensed administrator; and

(H) the signatures of the person who prepared the report and the licensed administrator.

(5) All reportable events, which have occurred in the facility, shall be reviewed on a monthly basis by the administrator and director of nurses. All situations which have a potential for risk shall be identified. A determination shall be made as to what preventative measures shall be implemented by the facility staff. Documentation of such determination shall be submitted to the active organized medical staff. This documentation shall be maintained for not less than three years.

(6) An investigation shall be initiated by the facility within twenty-four (24) hours of the discovery of a patient(s) with an injury of suspicious or unknown origin or receipt of an allegation of abuse. The investigation and the findings shall be documented and submitted to the facility's active organized medical staff for review. This document shall be maintained at the facility for a period of not less than three (3) years.

(7) Numbering. Each report shall be identified on each page with a number as follows: the number appearing on the facility license, the last two digits of the year and the sequential number of the report during the calendar year.

(8) Subsequent Reports. The licensed administrator shall submit subsequent reports relevant to any reportable event as often as is necessary to inform the Department of significant changes in the status of affected individuals or changes in material facts originally reported. Such reports shall be attached to a photocopy of the original reportable event report.

(h) Medical director.

(1) The medical director shall be a physician licensed to practice medicine in Connecticut and shall serve on the facility's active organized medical staff, shall have at least one year of prior clinical experience in adult medicine and shall be a member of the active medical staff of a general hospital licensed in Connecticut.

(2) The medical director shall have the following powers and responsibilities:

(A) Enforce the facility's by-laws governing medical care;

(B) Assure that quality medical care is provided in the facility;

(C) Serve as a liaison between the medical staff and administration;

(D) Approve or disapprove a patient's admission based on the facility's ability to provide adequate care for that individual in accordance with the facility's by-laws. The medical director shall have the authority to review any patient's record or examine any patient prior to admission for such purpose;

(E) Assure that each patient in the facility has an assigned personal physician;

(F) Provide or arrange for the provision of necessary medical care to the patient if the individual's personal physician is unable or unwilling to do so;

(G) Approve or deny applications for membership on the facility's active organized staff in accordance with subsection(i) (2) of these regulations;

(H) In accordance with the facility's by-laws, suspend or terminate the facility privileges of a medical staff member if that member is unable or unwilling to adequately care for a patient in accordance with standards set by any applicable local and state statutes and regulations, any federal regulations that may apply to a federal program in which the facility participates or facility by-laws;

(I) Visit the facility between the hours of 7 a.m. and 9 p.m. to assess the adequacy of medical care provided in the facility.

(i) A medical director of a chronic and convalescent nursing home shall visit the facility at least once every 7 days for such purpose.

(ii) A medical director of a rest home with nursing supervision shall visit the facility at least once every 30 days for such purpose;

(J) Receive reports from the director of nurses on significant clinical developments;

(K) Recommend to the administrator any purchases of medical equipment and/or services necessary to assure adequate patient care;

(L) Assist in the development of and participate in a staff orientation and training program in cooperation with the administrator and the director of nurses, as required by subsection (f) (3) (J) of these regulations.

(3) A record shall be kept by the facility of the medical director's visits and statements for review by the department. Such record shall minimally include the

date of visit, the names of the patients audited by the medical director, and a summary of problems discussed with the staff.

(i) Medical staff.

(1) Each facility shall have an active organized medical staff. All members of such staff shall possess a full and unrestricted Connecticut license for the practice of medicine. The active organized medical active staff at a chronic and convalescent nursing home shall include no less than three (3) physicians.

(2) The medical director shall approve or deny applications for membership on the active organized medical staff after consultation with the existing active organized medical staff, if any, and subject to the ratification of the governing body. In reviewing an applicant's qualifications for membership, the medical director shall consider whether the applicant:

(A) satisfies specific standards and criteria set in the medical by-laws of the facility; and

(B) is available by phone twenty-four (24) hours per day; is available to respond promptly in an emergency; and is able to provide an alternate physician or coverage whenever necessary.

(3) All appointments shall be made in writing and shall delineate the physician's duties and responsibilities. The letter of appointment shall be signed by the medical director and the applicant.

(4) Requirements for active organized medical staff members.

(A) Members shall meet at least once every ninety (90) days. Minutes shall be maintained for all such meetings. The regular business of the medical staff meetings shall include, but not be limited to, the hearing and consideration of reports and other communications from physicians, the director of nurses and other health professionals on:

(i) patient care topics, including all deaths, accidents, complications, infections;

(ii) medical quality of care evaluations; and

(iii) interdisciplinary care issues, including nursing, physical therapy, therapeutic recreation, social work, pharmacy, podiatry, or dentistry.

(B) Members shall attend at least fifty (50) percent of medical staff meetings per year. If two (2) or more members of the active medical staff are members of the same partnership or incorporated group practice, one (1) member of such an association may fulfill the attendance requirements for the other members of that association provided quorum requirements are met. In such case, the member in attendance shall be entitled to only one (1) vote.

(C) The active organized medical staff shall adopt written by-laws governing the medical care of the facility's patients. Such by-laws shall be approved by the medical director and the governing body. The by-laws shall include, but not necessarily be limited to:

(i) acceptable standards of practice for the medical staff;

(ii) criteria for evaluating the quality of medical care provided in the facility;

(iii) criteria by which the medical director shall decide the admission or denial of admission of a patient based on the facility's ability to provide care;

(iv) standards for the medical director to grant or deny privileges and to discipline or suspend the privileges of members of the medical staff, including assurance of a due process of appeal in the event of such actions;

(v) quorum requirements for staff meetings, provided a quorum may not be less than fifty (50) percent of the physicians on the active medical staff;

(vi) specific definition of services, if any, which may be provided by nonphysician health professionals such as physician's assistants or nurse practitioners;

(vii) standards to assure that members of the medical staff request medical consultants where the diagnosis is obscure, or where there is doubt as to the serious nature of the illness or as to treatment. Such standards shall minimally mandate that the consultant be qualified to render an opinion in the field in which the opinion is sought, and that the consultation include examination of the patient and medical record;

(viii) standards to assure that, in the event of the medical director's absence, inability to act, or vacancy of the medical director's office, another physician on the facility's active organized medical staff is temporarily appointed to serve in that capacity; and

(ix) conditions for privileges for the medical staff other than the active organized medical staff.

(5) Each member of the facility's medical staff shall sign a statement attesting to the fact that such member has read and understood the facility's medical and facility policies and procedures, and applicable statutes and regulations, and that such member will abide by such requirements to the best of his/her ability.

(j) Director of nurses.

(1) Qualifications.

(A) For a chronic and convalescent nursing home, the director of nurses, or any person acting in such capacity, shall be a nurse registered in Connecticut with at least one (1) year of additional education or experience in rehabilitative or geriatric nursing and one (1) year of nursing service administration.

(B) For a rest home with nursing supervision, the director of nurses, or any person acting in such capacity, shall be a nurse registered in Connecticut with at least one (1) year of additional education or experience in nursing service administration.

(2) The director of nurses shall be responsible for the supervision, provision, and quality of nursing care in the facility. The director of nurses' powers and duties shall include, but not necessarily be limited to, the following:

(A) development and maintenance of written nursing service standards of practice, to be ratified by the governing body; including but not necessarily limited to:

(i) definition of routine nursing care to be rendered by licensed nursing personnel, and determination of when more than routine care is needed; and

(ii) definition of routine care to be rendered by nurse's aides, and determination of when more than routine care is needed;

(B) coordination and integration of nursing services with other patient care services through periodic meetings or written reports;

(C) development of written job descriptions for nurses and nurse's aides;

(D) development and annual review of nursing service procedures;

(E) coordination and direction of the total planning for nursing services, including recommending to the administrator the number and levels of nurses and nurse's aides to be employed;

(F) selection, with the administrator's approval, of all nurses and nurse's aides;

(G) appointment of nurse supervisors as required by subsection (k) of section 19-13-D8t of the Regulations of Connecticut State Agencies;

(H) designation of a nurse in charge of each unit for all shifts;

(I) development of a schedule of daily rounds and assignment of duties for all nurses and nurse's aides to assure twenty-four (24) hour coverage sufficient to meet state regulatory requirements;

(J) assistance in the development of and participation in a staff orientation and training program, in cooperation with the administrator and medical director, as required by subsection (f) (3) (J) of section 19-13-D8t of the Regulations of Connecticut State Agencies;

(K) ensuring yearly written evaluation of nurses and nurse's aides;

(L) reporting significant clinical developments to the patient's personal physician and to the medical director; and

(M) appointment, with the approval of the administrator, of a nurse employed at the facility to act in the director's behalf in temporary absences.

(3) The director of nurses shall serve full-time and shall serve his/her entire shift between the hours of 7 a.m. and 9 p.m.

(3) An assistant director of nurses shall be appointed in any facility of one hundred and twenty (120) beds or more.

(k) Nurse supervisor. A nurse supervisor shall be a nurse registered in Connecticut. The responsibilities of the nurse supervisor shall include:

(1) Supervision of nursing activities during his/her tour of duty;

(2) Notification of a patient's personal physician if there is a significant change in the condition of the patient or if the patient requires immediate medical care, or notification of the medical director if the patient's personal physician does not respond promptly.

(l) Nurse's Aide Training and Employment

(1) On and after February 1, 1990, no person shall be employed for more than 120 days as a nurse's aide in a licensed chronic and convalescent nursing home or rest home with nursing supervision unless such person has successfully completed a training and competency evaluation program approved by the department and has been entered on the nurse's aide registry maintained by the department. No such facility shall employ such person as a nurse's aide without making inquiry to the registry pursuant to subdivision (2).

(A) Effective October 1, 2000, the commissioner shall adopt, and revise as necessary, a nurse's aide training program of not less than 100 hours and competency evaluation program for nurse's aides. The standard curriculum of the training program shall include a minimum of seventy-five (75) hours including but not limited to, the following elements: Basic nursing skills, personal care skills, care of cognitively impaired residents, recognition of mental health and social service needs, basic restorative services and residents' rights presented in both lecture and clinical settings. An additional twenty-five (25) hours of the standard nurse’s aide lecture and clinical setting curriculum shall include, but not be limited to specialized training in understanding and responding to physical, psychiatric, psychosocial and cognitive disorders. An individual enrolled in a nurse’s aide training program prior to October 1, 2000, may complete such program in accordance with the requirements in effect at the time of enrollment. A trainee's successful completion of training shall be demonstrated by the trainee's performance, satisfactory to the nurse's aide primary training instructor, or the elements required by the curriculum. Each licensed chronic and convalescent nursing home and rest home with nursing supervision that elects to conduct a nurse's aide training program shall submit such information on its nurse's aide training program as the commissioner may require on forms provided by the department. The department may re-evaluate the facility's nurse's aide training program and competency evaluation program for sufficiency at any time.

(B) The commissioner shall adopt, and revise as necessary, a nurse's aide competency evaluation program including, at least, the following elements: basic nursing skills, personal care skills, care of cognitively impaired residents, recognition of mental health and social service needs, basic restorative services and residents' rights and the procedures for determination of competency which may include a standardized test.

(C) Any person employed as a nurse's aide by a chronic and convalescent nursing home or a rest home with nursing supervision as of January 30, 1990 shall be entered on the nurse's aide registry if they meet the requirements set forth in OBRA in accordance with the current Federal Omnibus Budget Reconciliation Act of 1987 (OBRA, 87) as it may be amended from time to time. The facility shall provide such person with the initial preparation necessary to successfully complete a competency evaluation program, as may be required by OBRA '87. This competency evaluation program shall be approved and administered in accordance with this subsection.

(D) Qualifications of nurse's aide instructors

(i) The training of nurse's aides must be performed by or under the general supervision of a registered nurse who possesses a minimum of two years of nursing experience, at least one year of which must be in a chronic and convalescent nursing home or rest home with nursing supervision.

(ii) Instructors must have completed a course in teaching adults or have experience in teaching adults or supervising nurse's aides.

(iii) Qualified personnel from the health field may serve as trainers in the nurse's aide training program under the supervision of the nurse's aide primary training instructor provided they have a minimum of one year of experience in a facility for the elderly or chronically ill of any age within the immediately preceding five years. These health field personnel may include: Registered nurses, sanitarians, fire safety experts, nursing home administrators, gerontologists, psychologists, physical and occupational therapists therapeutic recreation specialists, speech/language/hearing therapists. All trainers should be, where applicable, licensed, registered and/or certified in their field.

(iv) Licensed practical nurses, under the supervision of the nurse's aide primary training instructor, may serve as trainers in the nurse's aide training program provided the licensed practical nurse has two years experience in caring for the elderly or chronically ill of any age.

(v) The training of nurse's aides may be performed under the general supervision of the director of nurses. The director of nurses is prohibited from performing the actual training of nurse's aides.

(E) The State Department of Education and the Board of Trustees of Community-Technical Colleges may offer such training programs and competency evaluation programs in accordance with these regulations.

(F) In accordance with this subsection any person who has not yet satisfactorily completed training as provided for herein, and who is employed by a facility for a period of one-hundred-twenty days or less, as a nurse's aide may be utilized only to perform tasks for which such person has received training and demonstrated competence to the satisfaction of the employer and shall perform such tasks only under the supervision of licensed nursing personnel. Record of any such training

and competence demonstration shall be maintained in the facility for the department's review for three years from the date of completion thereof. The employer may not use such person to satisfy staffing requirements as set forth in the Public Health Code.

(G) In accordance with this subsection a facility may use any person who has satisfactorily completed training, but has not yet satisfactorily completed the competency evaluation program as provided for herein, and who is employed by a facility for a period of 120 days or less as a nurse's aide to satisfy staffing requirements as set forth in the Public Health Code. Record of such training shall be maintained by the facility for the departments review for three years from the date of completion thereof.

(H) On and after February 1, 1990 any chronic and convalescent nursing home or rest home with nursing supervision that utilizes nurse's aides from a placement agency or from a nursing pool shall develop a mechanism to verify that such nurse's aide has been entered on the nurse's aide registry maintained by the department in accordance with subdivision (2).

(2) The department shall establish and maintain a registry of nurse's aides. Information in the nurse's aide registry shall include but not be limited to: name, address, date of birth, social security number, training site and date of satisfactory completion. It shall also contain any final determination by the department, after a hearing conducted pursuant to Chapter 54 of the Connecticut General Statutes, relative to a complaint against a nurse's aide, as well as any brief statement of such person disputing such findings, including resident neglect or abuse or misappropriation of resident property.

(3) If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of twenty-four (24) consecutive months during none of which the individual performed nursing or nursing-related services for monetary compensation, such individual shall complete a new training and competency evaluation program, or a new competency evaluation program.

(4) Any person who successfully completes or has successfully completed prior to January 1, 1989 the state-sponsored Nurse Assistant Training Program provided through the State Department of Education or through the Connecticut Regional Community College system shall be deemed to have completed a nurse's aide training and competency evaluation program approved by the commissioner in accordance with this subsection.

(5) Any person who has successfully completed a course or courses comprising not less than one-hundred hours of theoretical and clinical instruction in the fundamental skills of nursing in a practical nursing or registered nursing education program approved by the department with the advice and assistance of the State Board of Examiners for Nursing shall be deemed to have completed a nurse's aide training program approved by the commissioner in accordance with this subsection, if the curriculum meets the minimum requirements as set forth in this subsection.

(6) The department shall, upon receipt of an application and such supporting documents as the commissioner may require, place on the registry a nurse's aide who shows to the satisfaction of the department completion of a department approved:

(A) Nurse's aide training program, and

(B) Competency Evaluation program.

(7) A nurse's aide registered in another state or territory of the United States may be entered on the registry, provided the department is satisfied that such nurse's aide has completed a training and competency evaluation program equal to or

better than that required for registration in this state as of the date the nurse's aide was first registered in another state or territory of the United States.

(8) Subject to the provisions of section 20-102ff of the Connecticut General Statutes, a registered nurse or licensed practical nurse licensed in a state other than Connecticut whose license has been verified by the chronic and convalescent nursing home or rest home with nursing supervision as in good standing in the state in which he or she is currently licensed, or a registered nurse trained in another country who has satisfied the certification requirements of the Commission on Graduates of Foreign Nursing Schools, may be utilized as a nurse's aide in Connecticut for not more than a single one hundred-twenty (120) day period. Said licensed registered nurse or licensed practical nurse shall be deemed to have completed a nurse's aide training and competency evaluation program approved by the commissioner in accordance with this section. The department shall, upon receipt of an application and such supporting documents as the commissioner may require, enter said licensed registered nurse or licensed practical nurse on the nurse's aide registry.

(m) Nursing staff:

(1) Each facility shall employ sufficient nurses and nurse's aides to provide appropriate care of patients housed in the facility 24 hours per day, seven days per week.

(2) The number, qualifications, and experience of such personnel shall be sufficient to assure that each patient:

(A) receives treatment, therapies, medications and nourishments as prescribed in the patient care plan developed pursuant to subsection (o) (2) (I) of these regulations;

(B) is kept clean, comfortable and well groomed;

(C) is protected from accident, incident, infection, or other unusual occurrence.

(3) The facility's administrator and director of nurses shall meet at least once every 30 days in order to determine the number, experience and qualifications of staff necessary to comply with this section. The facility shall maintain written and signed summaries of actions taken and reasons therefore.

(4) There shall be at least one registered nurse on duty 24 hours per day, seven days per week.

(A) In a chronic and convalescent nursing home, there shall be at least one licensed nurse on duty on each patient occupied floor at all times.

(B) In a rest home with nursing supervision, there shall be at least one nurse's aide on duty on each patient-occupied floor at all times and intercom communication shall be available with a licensed nurse.

(5) In no instance shall a chronic and convalescent nursing home have staff below the following standards:

(A) Licensed nursing personnel:
7 a.m. to 9 p.m.: .47 hours per patient
9 a.m. to 7 a.m.: .17 hours per patient

(B) Total nursing and nurse's aide personnel:
7 a.m. to 9 p.m.: 1.40 hours per patient
9 a.m. to 7 a.m.: .50 hours per patient

(6) In no instance shall a rest home with nursing supervision staff below the following standards:

(A) Licensed nursing personnel:
7 a.m. to 9 p.m.: .23 hours per patient
9 a.m. to 7 a.m.: .08 hours per patient

(B) Total nursing and nurse's aide personnel:
7 a.m. to 9 p.m.: .70 hours per patient
9 a.m. to 7 a.m.: .17 hours per patient

(7) In facilities of 61 beds or more, the director of nurses shall not be included in satisfying the requirements of subdivisions (5) and (6) of this subsection.

(8) In facilities of 121 beds or more, the assistant director of nurses shall not be included in satisfying the requirements of subdivisions (5) and (6) of this subsection.

(n) Medical and professional services.

(1) A comprehensive medical history and medical examination shall be completed for each patient within forty-eight (48) hours of admission; however, if the physician who attended the patient in an acute or chronic care hospital is the same physician who will attend the individual in the facility, a copy of a hospital discharge summary completed within five (5) working days of admission and accompanying the patient may serve in lieu of this requirement. A patient assessment shall be completed within fourteen (14) days of admission and a patient care plan shall be developed within seven (7) days of completion of the assessment.

(A) The comprehensive history shall include, but not necessarily be limited to:

(i) chief complaints;
(ii) history of present illness;
(iii) review of systems;
(iv) past history pertinent to the total plan of care for the patient;
(v) family medical history pertinent to the total plan of care for the patient; and
(vi) personal and social history.

(B) The comprehensive examination shall include, but not necessarily be limited to:

(i) blood pressure;
(ii) pulse;
(iii) weight;
(iv) rectal examination with a test for occult blood in stool, unless done within one (1) year of admission;
(v) functional assessment; and
(vi) cognitive assessment, which for the purposes of these regulations shall mean an assessment of a patient's mental and emotional status to include the patient's ability to problem solve, decide, remember, and be aware of and respond to safety hazards.

(C) The patient assessment and patient care plan shall be developed in accordance with subparagraphs (H) and (I) of subsection (o) (2) of this section.

(2) Transferred Patients. When the responsibility for the care of a patient is being trantsferred from one health care institution to another, the patient must be accompanied by a medical information transfer document, which shall include the following information:

(A) name, age, marital status, and address of patient, institution transferring the patient, professional responsible for care at that institution, person to contact in case of emergency, insurance or other third party payment information;
(B) chief complaints, problems, or diagnoses;
(C) other information, including physical or mental limitations, allergies, behavioral and management problems;
(D) any special diet requirements;
(E) any current medications or treatments, and
(F) prognosis and rehabilitation potential.

(3) The attending physician shall record a summary of findings, problems and diagnoses based on the data available within seven (7) days after the patient's

admission, and shall describe the overall treatment plan, including dietary orders and rehabilitation potential and, if indicated, any further laboratory, radiologic or other testing, consultations, medications and other treatment, and limitations on activities.

(4) The following tests and procedures shall be performed and results recorded in the patient's medical record within thirty (30) days after the patient's admission:

(A) unless performed within one (1) year prior to admission;

(i) hematocrit, hemoglobin and red blood cell indices determination;

(ii) urinalysis, including protein and glucose qualitative determination and microscopic examination;

(iii) dental examination and evaluation;

(iv) tuberculosis screening by skin test or chest X-ray;

(v) blood sugar determination; and

(vi) blood urea nitrogen or creatinine;

(B) unless performed within two (2) years prior to admission:

(i) visual acuity, grossly tested, for near and distant vision; and

(ii) for women, breast and pelvis examinations, including Papanicolau smear, except the Papanicolau smear may be omitted if the patient is over sixty (60) years of age and has had documented repeated satisfactory smear results without important atypia performed during the patient's sixth decade of life, or who has had a total hysterectomy;

(C) unless performed within five (5) years prior to admission:

(i) tonometry on all sighted patients forty (40) years or older; and

(ii) screening and audiometry on patients who do not have a hearing aid; and

(D) unless performed within ten (10) years prior to admission:

(i) tetanus-diphtheria toxoid immunization for patients who have completed the initial series, or the initiation of the initial series for those who have not completed the initial series; and

(ii) screening for syphilis by a serological method.

(5) Physician Visits.

(A) Each patient in a chronic and convalescent nursing home shall be examined by his/her personal physician at least once every thirty (30) days for the first ninety (90) days following admission. After ninety (90) days, alternative schedules for visits may be set if the physician determines and so justifies in the patient's medical record that the patient's condition does not necessitate visits at thirty (30) day intervals. At no time may the alternative schedule exceed sixty (60) days between visits.

(B) Each patient in a rest home with nursing supervision shall be examined by his/her personal physician at least once every sixty (60) days, unless the physician decides this frequency is unnecessary and justifies the reason for an alternate schedule in the patient's medical record. At no time may the alternative schedule exceed one hundred and twenty (120) days between visits.

(6) No medication or treatments shall be given without the order of a physician or a health care practitioner with the statutory authority to prescribe medications or treatments. If orders are given verbally or by telephone, they shall be recorded by an on duty licensed nurse or on duty health care practitioner with the statutory authority to accept verbal or telephone orders with the physician's name, and shall be signed by the physician on the next visit.

(7) Annually, each patient shall receive a comprehensive medical examination, at which time the attending physician shall update the diagnosis and revise the individual's overall treatment plan in accordance with such diagnosis. The

comprehensive medical exam shall minimally include those services required in subdivision (1) (B) of this subsection.

(9) Professional services provided to each patient by the facility shall include, but not necessarily be limited to, the following:

(A) monthly:

(i) blood pressure, and

(ii) weight check;

(B) yearly:

(i) hematocrit, hemoglobin and red blood cell indices determination;

(ii) urinalysis, including determination of qualitative protein glucose and microscopic examination of urine sediment;

(iii) immunization against influenza;

(iv) blood urea nitrogen or creatinine;

(v) dental examination and evaluation;

(vi) rectal examination, including a determination for occult blood in stool, on patients forty (40) years or over; and

(vii) breast examination on all women;

(C) every two (2) years, visual acuity, grossly tested, for near and distant vision for sighted patients;

(D) every five (5) years:

(i) screening audiometry for patients without a hearing aid; and

(ii) tonometry for sighed patients forty (40) years or over; and

(E) every ten (10) years, tetanus-diphtheria toxoid immunization following completion of initial series.

(10) The requirements in this subsection for tests, procedures, and immunizations need not be repeated if previously done within the time period prescribed in this subsection and documentation of such is recorded in the patient's medical record. Such tests, procedures, and immunizations shall be provided to the patient given the individual's consent provided no medical reason or contraindication exists, or the attending physician determines that the test, procedure, or immunization is not medically necessary. If a medical reason or contraindication exists, or the attending physician determines that the test, procedure, or immunization is not medically necessary it shall be so noted by the attending physician in he patient's medical record.

(o) Medical records.

(1) Each facility shall maintain a complete medical record for each patient. All parts of the record pertinent to the daily care and treatment of the patient shall be maintained on the nursing unit in which the patient is located.

(2) The complete medical record shall include, but not necessarily be limited to:

(A) patient identification data, including name, date of admission, most recent address prior to admission, date of birth, sex, marital status, religion, referral source, Medicare/Medicaid number(s) or other insurance numbers, next of kin or guardian and address and telephone number;

(B) name of patient's personal physician;

(C) signed and dated admission history and reports of physical examinations;

(D) signed and dated hospital discharge summary, if applicable;

(E) signed and dated transfer form, if applicable;

(F) complete medical diagnosis;

(G) all initial and subsequent orders by the physician;

(H) a patient assessment that shall include but not necessarily be limited to, health history, physical, mental and social status evaluation of problems and rehabilitation potential, completed within fourteen (14) days of admission by all disciplines involved in the care of the patient and promptly after a change in condition that is expected to have lasting impact upon the patient's physical, mental or social functioning,

conducted no less than once a year, reviewed and revised no less than once every ninety (90) days in order to assure its continued accuracy;

(I) a patient care plan, based on the patient assessment, developed within seven (7) days of the completion of the assessment by all disciplines involved in the care of the patient and consistent with the objectives of the patient's personal physician, that shall contain the identification of patient problems and needs, treatments, approaches and measurable goals, and be reviewed at least once every ninety (90) days thereafter;

(J) a record of visits and progress notes by the physician;

(K) nurses notes to include current condition, changes in patient condition, treatments and responses to such treatments;

(L) a record of medications administered including the name and strength of drug, date, route and time of administration, dosage administered, and, with respect to PRN medications, reasons for administration and patient response/result observed;

(M) documentation of all care and ancillary services rendered;

(N) summaries of conferences and records of consultations;

(O) record of any treatment, medication or service refused by the patient including the visit of a physician, signed by the patient, whenever possible, including a statement by a licensed person that such patient was informed of the medical consequences of such refusal; and

(P) discharge plans, as required by Section 19a-535 of the Connecticut General Statutes and subsection (p) of this section.

(3) All entries in the patient's medical record shall be typewritten or written in ink and legible. All entries shall be verified according to accepted professional standards.

(4) Medical records shall be safeguarded against loss, destruction or unauthorized use.

(5) All medical records, originals or copies, shall be preserved for at least ten (10) years following death or discharge of the patient.

(p) Discharge planning.

(1) All discharge plans for patients transferred or discharged from a facility shall be in writing and shall be signed by the person preparing the plan, the medical director or the patient's personal physician, and the administrator of the discharging facility.

(2) Receipt of the discharge plan and acknowledgement of consultation with respect thereto shall be evidenced by the signature of the patient, or that patient's legally liable relative, guardian or conservator.

(3) All discharge plans shall be maintained as a part of the patient's medical record.

(4) In addition to the requirements of the Connecticut General Statutes Section 19a-35 (c), the following information shall be included in a written notice of discharge or transfer:

(A) In the case of residents with developmental disabilities, the name, mailing address and telephone number of the agency responsible for the protection and advocacy of the developmentally disabled;

(B) In the case of mentally ill residents, the name, mailing address and telephone number of the agency responsible for the protection and advocacy of the mentally ill.

(q) Dietary services.

(1) Each facility shall meet the daily nutritional needs of the patients by providing dietary services directly or through contract.

(2) The facility shall:

(A) Provide a diet for each patient, as ordered by the patient's personal physician, based upon current recommended dietary allowances of the Food and Nutrition Board of the National Academy of Sciences, National Research Council, adjusted for age, sex, weight, physical activity, and therapeutic needs of the patients;

(B) Adopt a diet manual, as recommended by the facility dietitian or dietary consultant and approved by the facility's medical staff. Such manual shall be used to plan, order, and prepare regular and therapeutic diets;

(C) Employ a dietetic service supervisor, who shall supervise the overall operation of the dietary service. If such supervisor is not a dietitian, the facility shall contract for regular consultation of a dietitian;

(D) Employ sufficient personnel to carry out the functions of the dietary service and to provide continuous service over a period of 12 hours, which period shall include all mealtimes.

(3) The facility shall ensure that the dietary service:

(A) Considers the patients' cultural backgrounds, food habits, and personal food preferences in the selection of menus and preparation of foods and beverages pursuant to subdivisions (2)(A) and (2) (B) of this subsection;

(B) Has written and dated menus, approved by a dietitian, planned at least seven days in advance;

(C) Posts current menus and any changes thereto with the minimum portion sizes in a conspicuous place in both food preparation and patient areas;

(D) Serves at least three meals, or their equivalent, daily at regular hours, with not more than a 14 hour span between evening meal and breakfast;

(E) Provides appropriate food substitutes of similar nutritional value to patients who refuse the food served;

(F) Provides bedtime nourishments for each patient, unless medically contraindicated and documented in the patient's care plan;

(G) Provides special equipment, implements or utensils to assist patients while eating, when necessary;

(H) Maintains at least three day supply of staple foods at all times.

(4) All patients shall be encouraged to eat in the dining room unless medically contraindicated.

(5) Records of menus served and food purchased shall be maintained for at least 30 days.

(r) Therapeutic Recreation.

(1) Each facility shall have a therapeutic recreation program. The program shall include mentally and physically stimulating activities to meet individual needs and interests, and shall be consistent with the overall plan of care for each patient.

(2) Each facility shall employ therapeutic recreation director(s).

(A) Persons employed as therapeutic recreation director(s) in a chronic and convalescent nursing home and rest home with nursing supervision on or before June 30, 1982 shall have a minimum of a high school diploma or high school equivalency, and shall have completed a minimum of 80 hours of training in therapeutic recreation. As of July 1, 1992, persons who met these criteria but who have not been employed as therapeutic recreation director(s) in a chronic and convalescent nursing home and/or rest home with nursing supervision for two continuous years immediately preceding reemployment in such capacity shall be required to meet the requirements of Section 19-13-D8t (r) (2) (c).

(B) Persons beginning employment as therapeutic recreation director(s) in a chronic and convalescent nursing home and/or rest home with nursing supervision between July 1, 1982 and June 30, 1992 shall have the following minimum qualifications:

(i) An Associates Degree with a major emphasis in therapeutic recreation; or

(ii) Enrollment in a Connecticut certificate program in therapeutic recreation; or

(iii) A Bachelors Degree in a related field and one year of full time employment in therapeutic recreation in a health care facility; or

(iv) A Bachelors Degree in a related field and six credit hours in therapeutic recreation; or

(v) An Associates Degree in a related field and two years of full time employment in therapeutic recreation in a health care facility; or

(vi) An Associates Degree in a related field and nine credit hours in therapeutic recreation.

(vii) As of July 1, 1992, persons who met these criteria but who have not been employed as a therapeutic recreation director in a health care facility for two continuous years immediately preceding reemployment in such capacity shall be required to meet the requirements of Section 19-13-D8t (r) (2) (C).

(C) Persons beginning employment as therapeutic recreation director(s) in a chronic and convalescent nursing home and/or rest home with nursing supervision on or after July 1, 1992 shall have the following minimum qualifications:

(i) An associates degree with a major emphasis in therapeutic recreation; or

(ii) A high school diploma or equivalency and enrollment within six months of employment in a Connecticut certificate program in therapeutic recreation. Each facility shall maintain records of the individual's successful completion of courses and continued participation in a minimum of one course per semester; or

(iii) A bachelors degree in a related field and one year of full time employment in therapeutic recreation in a health care facility; or

(iv) A bachelors degree in a related field and six credit hours in therapeutic recreation; or

(v) An associates degree in a related field and two years of full time employment in therapeutic recreation in a health care facility; or

(vi) An associates degree in a related field and nine credit hours in therapeutic recreation.

(D) "Related field" in subparagraphs (B) and (C) of this subdivision shall include but not be limited to the following: sociology, social work, psychology, recreation, art, music, dance or drama therapy, the health sciences, education or other related field as approved by the commissioner or his/her designee.

(3) Therapeutic recreation director(s) shall be employed in each facility sufficient to meet the following ratio of hours per week to the number of licensed beds in the facility: 1 to 15 beds, 10 hours during any three days; 16 to 30 beds, 20 hours during any five days Each additional 30 beds or fraction thereof, 20 additional hours.

(4) Monthly calendars of therapeutic recreation activities and patient participation records for each level of care shall be maintained at each facility for twelve months. These shall be available for review by representatives of the department.

(A) The calendar for the current month for each level of care shall be completed by the first day of the month.

(B) Records of patient participation shall be maintained on a daily basis.

(C) The facility shall submit these records to the department upon the department's request.

(5) An individual therapeutic recreation plan shall be developed for each patient, which shall be incorporated in the overall plan of care for that patient.

(s) Social Work.

(1) Definitions:

(A) Social Work Designee A social work designee shall have at least an associate's degree in social work or in a related human service field. Any

person employed as a social work designee on January 1, 1989 shall be eligible to continue in the facility of employment without restriction.

(B) Qualified Social Worker A qualified social worker shall hold at least a bachelor's degree in social work from a college or university which was accredited by the Council on Social Work Education at the time of his or her graduation, and have at least one year social work experience in a health care facility. An individual who has a bachelor's degree in a field other than social work and a certificate in Post Baccalaureate Studies in Social Work awarded before the effective date of these regulations by a college accredited by the Department of Higher Education, and at least one year social work experience in a health care facility, may perform the duties and carry out the responsibilities of a qualified social worker for up to three years after the effective date of these regulations.

(C) Qualified Social Work Consultant A qualified social work consultant shall hold at least a master's degree in social work from a college or university which was accredited by the Council on Social Work Education at the time of his or her graduation and have at least one year post-graduate social work experience in a health care facility. An individual who holds a bachelor's degree in social work from a college or university which was accredited by the Council on Social Work Education at the time of his or her graduation, and is under contract as a social work consultant on January 1, 1989, shall be eligible to continue functioning without restriction as a social work consultant in the facility(ies) which had contracted his or her services.

(2) Each facility shall employ social work service staff to meet the social and emotional problems and/or needs of the patients based on their medical and/or psychiatric diagnosis.

(3) The administrator of the facility shall designate in writing a qualified social worker or social work designee as responsible for the social work service.

(4) The social work service shall be directed by a qualified social worker or a social work designee. If the service is under the direction of a social work designee the facility shall contract for the regular consultation of a qualified social work consultant at least on a quarterly basis.

(5) Social work service staff shall be employed in each facility sufficient to meet the needs of the patients but not less than the following ratio of hours per week to the number of licensed beds in the facility:

(A) One (1) to thirty (30) beds, ten (10) hours per week.

(B) Thirty-one (31) to sixty (60) beds, twenty (20) hours per week.

(C) Each additional thirty (30) beds or fraction thereof, ten (10) additional hours.

(6) Written social work service policies and procedures shall be developed and implemented by a qualified social worker, or social work designee under the direction of a qualified social work consultant, and ratified by the governing body of the facility. Such standards shall include, but not be limited to:

(A) Ensuring the confidentiality of all patients' social, emotional, and medical information, in accordance with the General Statutes of Connecticut Section 19a-550 (a) (8).

(B) Requiring a prompt referral to an appropriate agency for patients or families in need of financial assistance and requiring that a record is maintained of each referral to such agency in the patient's medical record.

(7) The social work service shall help each patient to adjust to the social and emotional aspects of the patient's illness, treatment, and stay in the facility. The medically related social and emotional needs of the patient and family shall be identified, a plan of care developed, and measurable goals set in accordance

with the Regulations of Connecticut State Agencies Sections 19-13-D8t (o) (2) (H) and (o) (2) (I).

(8) All staff of the facility shall receive inservice training by or under the direction of a qualified social worker or social work designee each year concerning patients' personal and property rights pursuant to Section 19a-550 of the Connecticut General Statutes.

(9) All staff of the facility shall receive inservice training by a qualified social worker or qualified social work consultant each year in an area specific to the needs of the facility's patient population.

(10) A qualified social worker or social work designee shall participate in planning for the discharge and transfer of each patient.

(11) Office facilities shall be easily accessible to patients and staff or alternate arrangements shall be available. Each facility shall ensure privacy for interviews between staff and: patients, patients' families and patients' next friend.

(t) Infection control.

(1) Each facility shall have an infection control committee which meets at least quarterly, and whose membership shall include representatives from the facility's administration, medical staff, nursing staff, pharmacy, dietary department, maintenance, and housekeeping. Minutes of all meetings shall be maintained.

(2) The committee shall be responsible for the development of:

(A) an infection prevention, surveillance, and control program which shall have as its purpose the protection of patients and personnel from institution-associated or community-associated infections, and

(B) policies and procedures for investigating, controlling and preventing infections in the facility and recommendations to implement such policy.

(3) The facility shall designate a registered nurse to be responsible for the day-to-day operation of a surveillance program under the direction of the infection control committee.

(u) Emergency preparedness plan.

(1) The facility shall have a written emergency preparedness plan which shall include procedures to be followed in case of medical emergencies, or in the event all or part of the building becomes uninhabitable because of a natural or other disaster. The plan shall be submitted to the local fire marshal or, if none, the state fire marshal for comment prior to its adoption.

(2) The plan shall specify the following procedures:

(A) Identification and notification of appropriate persons;

(B) Instructions as to locations and use of emergency equipment and alarm systems;

(C) Tasks and responsibilities assigned to all personnel;

(D) Evacuation routes;

(E) Procedures for relocation and/or evacuation of patients;

(F) Transfer of casualties;

(G) Transfer of records;

(H) Care and feeding of patients;

(I) Handling of drugs and biologicals.

(3) A copy of the plan shall be maintained on each nursing unit and service area. Copies of those sections of the plan relating to subdivisions (2) (B) and (2) (D) above shall be conspicuously posted.

(4) Drills testing the effectiveness of the plan shall be conducted on each shift at least four times per year. A written record of each drill, including the date, hour, description of drill, and signatures of participating staff and the person in charge shall be maintained by the facility.

(5) All personnel shall receive training in emergency preparedness as part of their employment orientation. Staff shall be required to read and acknowledge by signature understanding of the emergency preparedness plan as part of the

orientation. The content and participants of the training orientation shall be documented in writing.

(v) Physical plant.

(1) Owner certification.

(A) All owners of real property or improvements thereon that are used as or in connection with an institution as defined by section 19a-490 of Connecticut General Statutes, shall apply to the Department for a Certificate of Compliance with the Regulations of Connecticut State Agencies.

(B) Such application shall be made on forms provided by the department and shall include the following information:

(i) the names, addresses and business telephone numbers of the owner which term shall include any person who owns a ten (10) percent or greater interest in the property equity, any general partner if the owner is a limited partnership, any officer, director and statutory agent for service of process if the owner is a corporation, and any partner if the owner is a general partnership;

(ii) a statement as to equity owned, that shall include the fair market value of the property as reflected by the current municipal assessment and all outstanding mortgages and liens including the current amounts due and names and addresses of holders;

(iii) if the property is owned by a person other than the licensee, a copy of the current lease or a summary thereof that shall include all rental payments required including additional rent of any kind and tax payments, any termination provisions, and a statement setting forth the responsibilities and authority of the respective parties to maintain or renovate the said real property and improvements; and

(iv) if the owner is a corporation and is incorporated in a state other than Connecticut, a Certificate of Good Standing issued by the state of incorporation.

(C) upon receipt of such application, if the Department has conducted a licensure inspection within the preceding nine (9) months, the Department shall either:

(i) issue the requested certificate, or

(ii) advise the applicant of repairs that must be made to comply with the Regulations of Connecticut State Agencies.

(D) If the Department has not conducted such an inspection, it shall do so within sixty (60) days of receipt of the application and within thirty (30) days of such inspection shall either:

(i) issue the requested certificate; or

(ii) advise the applicant of repairs that must be made to comply with the Regulations of Connecticut State Agencies.

(E) Upon receipt of satisfactory evidence that said repairs have been made or will be made in a timely fashion, the Department shall issue the requested certificate.

(F) No repair shall be required pursuant hereto if the condition cited preexisted the effective date of the adoption of the violated standard unless the commissioner or his/her designee shall make a specific determination that the repair is necessary to protect the health, safety or welfare of the patients in the concerned facility.

(G) Any owner who commences any proceeding or action that affects or has the potential to affect the rights of a licensee of a facility or institution as defined in Section 19a-490 of the Connecticut General Statutes to

continue to occupy leased premises shall immediately notify the Department of such proceeding or action by certified mail.

(2) The standards established by the following sources for the construction, alteration or renovation of all facilities as they may be amended from time to time, are hereby incorporated and made a part hereof by reference. In the event of inconsistent provisions, the most stringent standards shall apply:
- (A) State of Connecticut Basic Building Codes;
- (B) State of Connecticut Fire Safety Code;
- (C) National Fire Protection Association Standards, Health Care Facilities, No. 99;
- (D) AIA publication, "Guidelines for Construction and Equipment of Hospital and Medical Facilities," 1992-1993;
- (E) local fire, safety, health, and building codes and ordinances; and.
- (F) other provisions of the Regulations of Connecticut State Agencies that may apply.

(3) Any facility licensed after the effective date of these regulations shall conform with the construction requirements described herein. Any facility licensed prior to the effective date of these regulations shall comply with the construction requirements in effect at the time of licensure; provided, however, that if the commissioner or his/her designee shall determine that a pre-existing non-conformity with this subsection creates serious risk of harm to patients in a facility, the commissioner may order such facility to comply with the pertinent portion of this subsection.

(4) Review of plans. Plans and specifications for new construction and rehabilitation, alteration, addition, or modification of an existing structure shall be approved by the Department on the basis of compliance with the Regulations of Connecticut State Agencies after the approval of such plans and specifications by local building inspectors and fire marshals, and prior to the start of construction.

(5) Site.
- (A) All facilities licensed for more than one hundred and twenty (120) beds shall be connected to public water and sanitary sewer systems.
- (B) Each facility shall provide the following:
  - (i) roads and walkways to the main entrance and service areas, including loading and unloading space for delivery trucks;
  - (ii) paved exits that terminate at a public way; and
  - (iii) an open outdoor area with a minimum of one hundred (100) square feet per patient excluding structures and paved parking areas.

(6) The facility shall provide sufficient space to accommodate all business and administrative functions.

(7) Patient rooms.
- (A) Maximum room capacity shall be four (4) patients.
- (B) Net minimum room area, exclusive of closets, and toilet room, shall be at least one hundred (100) square feet for single bedrooms, and eighty (80) square feet per individual in multi-bed rooms. No dimension of any room shall be less than ten (10) feet.
- (C) No bed shall be between two (2) other patient beds, and at least a three (3) foot clearance shall be provided at the sides and the foot of each bed.
- (D) Window sills shall not be higher than three (3) feet above the finished floor. Storm windows or insulated glass windows shall be provided. All windows used for ventilation shall have screens.
- (E) The following equipment shall be provided for each patient in each room:
  - (i) one (1) closet with clothes rod and shelf of sufficient size and design to hang clothing;
  - (ii) one (1) dresser with three (3) separate storage areas for patient's clothing;

(iii) one (1) adjustable hospital bed with gatch spring, side rails, and casters provided, however, that a rest home with nursing supervision need not provide a hospital bed for a patient whose patient care plan indicates that such equipment is unnecessary and that a regular bed is sufficient;
(iv) one (1) moisture proof mattress;
(v) one (1) enclosed bedside table;
(vi) one (1) wall-mounted overbed light;
(vii) one (1) overbed table;
(viii) one (1) armchair; and
(ix) one (1) mirror.

(F) Sinks.
(i) In single or double rooms, one (1) sink shall be provided in the toilet room.
(ii) In rooms for three (3) and more individuals, there shall be one (1) sink in the patient room and one (1) sink in the toilet room.

(G) Curtains that allow for complete privacy for each individual in multi-bed rooms shall be provided.

(H) All patient rooms shall open into a common corridor and shall have at least one (1) outside window wall.

(I) All patient rooms shall be located within one hundred and thirty (130) feet of a nursing station.

(8) Patient toilet and bathing facilities.

(A) A toilet room shall be directed accessible from each patient room. One (1) toilet room may serve two (2) rooms but not more than four (4) beds.

(B) One (1) shower stall or bathtub shall be provided for each fifteen (15) beds not individually served. A toilet and sink shall be directly accessible to the bathing area.

(C) There shall be at least one (1) bathtub in each nursing unit. At least one (1) bathtub per floor shall be elevated and have at least three (3) feet clearance on three (3) sides.

(D) Bathing and shower rooms shall be of sufficient size to accommodate one (1) patient and one (1) attendant and shall not have curbs. Controls shall be located outside shower stalls.

(9) Nursing service areas.

(A) Each facility shall provide the following nursing service areas for each thirty (30) beds or fraction thereof:
(i) a nursing station of at least one hundred (100) square feet which may serve up to sixty (60) beds if an additional fifty (50) square feet are provided;
(ii) a nurses' toilet room convenient to each nursing station;
(iii) a clean workroom of at least eighty (80) square feet which may serve up to sixty (60) beds if an additional twenty (20) square feet are provided;
(iv) a soiled workroom of at least sixty (60) square feet which may serve up to sixty (60) beds if an additional thirty (30) square feet are provided, and shall minimally contain a handwashing sink, a bedpan flushing and washing device and a flush rim sink;
(v) a medicine room of at least thirty-five (35) square feet adjacent to the nursing station, secured with a key bolted door lock, and including one (1) sink, one (1) refrigerator, locked storage space, a non-portable steel narcotics locker with a locked cabinet, and equipment for preparing and dispensing of medications;
(vi) clean linen storage area;
(vii) an equipment storage room of at least eighty (80) square feet; and

(viii) storage space of at least twelve (12) square feet for oxygen cylinders.

(B) Each facility shall provide at least one (1) nourishment station on each floor, that shall include storage space, one (1) sink, and one (1) refrigerator.

(10) Medical and therapeutic treatment facilities.

(A) Each facility shall provide one (1) examination room, with a treatment table, storage space, and a sink.

(B) Each chronic and convalescent nursing home shall provide an exercise and treatment room for physical therapy, consisting of at least two hundred (200) square feet. Such room shall include a sink, cubicle curtains around treatment areas, storage space for supplies and equipment, and a toilet room.

(11) Common patient areas. Each facility shall provide the following:

(A) at least one (I) lounge on each floor with a minimum area of two hundred and twenty-five (225) square feet for each thirty (30) beds or fraction thereof;

(B) a dining area in a chronic and convalescent facility with a minimum of fifteen (15) square feet per patient with total area sufficient to accommodate at least fifty (50) percent of the total patient capacity; a dining area in a rest home with nursing supervision with a minimum capacity of fifteen (15) square feet per patient with total area sufficient to accommodate the total patient capacity; and

(C) a recreation area, that shall consist of a minimum of twelve (12) square feet per bed, of which fifty (50) percent of the aggregate area shall be located within one (1) space with an additional one hundred (100) square feet provided for storage of supplies and equipment.

(12) Dietary facilities. Each facility shall provide dietary facilities, that shall include the following:

(A) a kitchen, centrally located, segregated from other areas and large enough to allow for working space and equipment for the proper storage, preparation and storage of food;

(B) a dishwashing room, that shall be designed to separate dirty and clean dishes and includes a breakdown area.

(C) disposal facilities for waste, separate from the food preparation or patient areas;

(D) stainless steel tables and counters;

(E) an exhaust fan over the range and steam equipment;

(F) a water supply at the range;

(G) a breakdown area and space for returnable containers;

(H) office space for the food service supervisor or dietitian; and

(I) janitor's closet.

(13) Miscellaneous facilities. Each facility shall provide:

(A) A personal care room, that shall include equipment for hair care and grooming needs; and

(B) A holding room for deceased persons that is at least six (6) feet by eight (8) feet, mechanically ventilated, and used solely for its specific purpose.

(14) Storage.

(A) General storage space shall consist of at least ten (10) square feet per bed, and shall be located according to use and demand.

(B) Storage space for patient's clothing and personal possessions not kept in the room shall consist of at least two (2) feet by three (3) feet by four (4) feet per bed and shall be easily accessible.

(15) Laundry.

(A) The facility shall handle and process laundry in a manner to insure infection control.

(B) No facility without public water and sanitary sewers may process laundry on site. Off site services shall be performed by a commercial laundering service.

(C) The facility shall provide the following:
- (i) a soiled linen holding room;
- (ii) a clean linen mending and storage room;
- (iii) linen cart storage space; and
- (iv) linen and towels sufficient for three (3) times the licensed capacity of the facility.

(D) On site processing. The following shall be required for facilities that process laundry on site:
- (i) laundry processing room, with commercial equipment;
- (ii) storage space for laundry supplies;
- (iii) a handwashing sink;
- (iv) a deep sink for soaking;
- (v) equipment for ironing; and
- (vi) janitor's closet.

(16) Mechanical systems.

(A) Elevators.
- (i) Where patient beds or patient facilities are located on any floor other than the main entrance, the size and number of elevators shall be based on the following criteria: number of floors, number of beds per floor, procedures or functions performed on upper floors, and level of care provided.
- (ii) In no instance shall elevators provided be less than the following: for one (1) to sixty (60) beds located above the main floor, one (1) hospital type elevator; for sixty-one (61) to two hundred (200) beds located above the main floor, two (2) hospital type elevators; and for two hundred and one (201) to three hundred and fifty (350) beds located above the main floor, three (3) hospital type elevators. For facilities with more than three hundred and fifty (350) beds located above the main floor, the number of elevators shall be determined from a study of the facility plan.
- (iii) Elevator vestibules shall have two (2) hour construction with self-closing one and one-half (1 1/2) inch fire rated doors held open by electromagnetic devices that are connected to an automatic alarm system.

(B) Steam and hot water systems.
- (i) Boilers shall have a capacity sufficient to meet the Steel Boiler Institute or Institute of Boiler and Radiator Manufacturer's net ratings to supply the requirements of all systems and equipment.
- (ii) Provisions shall be made for auxiliary emergency service.

(C) Air conditioning, heating and ventilating systems.
- (i) All air-supply and air-exhaust systems for interior rooms shall be mechanically operated. All fans serving exhaust systems shall be located at or near the point of discharge from the building.
- (ii) Corridors shall not be used to supply air to or exhaust air from any room.
- (iii) All systems that serve more than one (1) smoke or fire zone shall be equipped with smoke detectors to shut down fans automatically. Access for maintenance of detectors shall be provided at all dampers.

(D) Plumbing and other piping systems.
- (i) Plumbing fixtures. All fixtures used by medical staff, nursing staff, and food handlers shall be trimmed with valves that can be

operated without the use of hands. Where blade handles are used for this purpose, they shall be at least four and one-half (4 1/2) inches in length, except that handles on clinical sinks shall be not less than six (6) inches long.

(ii) Water supply systems. Systems shall be designed to supply water to the fixtures and equipment on the upper floor at a minimum pressure of fifteen (15) pounds per square inch during maximum demand periods. Each water service main, branch main, riser and branch to a group of fixtures shall be valved. Stop valves shall be provided at each fixture. Hot water plumbing fixtures intended for patient use shall carry water at temperatures between one hundred and five degrees (105°) and one hundred and twenty degrees (120°) Fahrenheit.

(17) Electrical system.

(A) Circuit breakers or fusible switches shall be enclosed with a dead-front type of assembly. The main switchboard shall be located in a separate enclosure accessible only to authorized persons.

(B) Lighting and appliance panel boards shall be provided for the circuits on each floor. This requirement does not apply to emergency system circuits.

(C) All spaces within the building, approaches, thereto, and parking lots shall have electric lighting. Patients' bedrooms shall have general, overbed, and night lighting. A reading light shall be provided for each patient. Patients' overbed lights shall not be switched at the door. Night lights shall be switched at the nursing station.

(D) Receptacles.

(i) Each patient room shall have at least one (1) duplex grounding receptacle on each wall.

(ii) Corridors. Duplex grounding receptacles for general use shall be installed approximately fifty (50) feet apart in all corridors and within twenty-five (25) feet of ends of corridors.

(iii) Any facility constructed shall conform with the requirements described herein. Receptacles that provide emergency power shall be red and indicate their use. One (1) such receptacle shall be installed next to each resident's bed.

(E) A nurses' calling station shall be installed at each patient bed, toilet bathing fixture and patient lounges:

(i) All calls shall register a visible and audible sound at the station, and shall activate a visible signal in the corridor at the patient's door, in the clean and soiled workrooms and in the nourishment station of the nursing unit from which the patient is signaling. In multi-corridor nursing units, intersections shall have additional visible signals.

(ii) In rooms containing two (2) or more stations, indicating lights shall be provided at each station.

(iii) No more than two (2) cords shall be used at each station.

(iv) Stations at toilet and bathing fixtures shall be emergency stations. The emergency signal shall be cancelled only at the source of the call.

(v) Nurses' call systems shall provide two-way voice communication and shall be equipped with an indicating light at each station. Such lights shall remain lighted as long as the voice circuit is operative.

(18) Emergency service.

(A) The facility shall provide on the premises an emergency source of electricity, that shall have the capacity to deliver eighty (80) percent of

normal power and shall be sufficient to provide for regular nursing care and treatment and the safety of the occupants. Such source shall be reserved for emergency use.

(B) When fuel to the facility is not piped from a utility distribution system, fuel shall be stored at the facility sufficient to provide seventy-two (72) hours of service.

(19) Details of construction.

(A) Patient rooms. Patient rooms shall be numbered and have the room capacity posted.

(B) Doors.

(i) Minimum door widths to patient sleeping rooms shall be three feet-ten inches (3'-10").

(ii) Doors to utility rooms shall be equipped with hospital-type hardware that will permit opening without the use of the hands.

(iii) Door hardware for patient use shall be of a design to permit ease of opening.

(iv) Doors to patient room toilet rooms and tub or shower rooms may be lockable if provided with hardware that will permit access in any emergency. Such a room shall have visual indication that it is occupied.

(v) No doors shall swing into the corridor except closet doors.

(C) Corridors.

(i) Minimum width of patient use corridors shall be eight (8) feet.

(ii) Handrails shall be provided on both sides of patient use corridors. Such handrails shall have ends returned to the walls, a height of thirty-one (31) inches above the finished floor and shall protrude one and one-half (1 1/2) inches from the wall.

(iii) No objects shall be located so as to project into the required width of corridors.

(D) Grab bars, with sufficient strength and anchorage to sustain two hundred and fifty (250) pounds for five (5) minutes shall be provided at all patients' toilets, showers, and tubs.

(E) Linen and refuse chutes shall be designed as follows:

(i) Service openings to chutes shall be located in a room of not less than two (2) hour fire-resistive construction, and the entrance door to such room shall be a Class "B," one and one-half (1 1/2) hour rated door.

(ii) Gravity-type chutes shall be equipped with washdown device.

(iii) Chutes shall terminate in or discharge directly into collection rooms. Separate collection rooms shall be provided for refuse and linen.

(F) Dumbwaiters, conveyers, and material handling systems shall open into a room enclosed by not less than two (2) hours fire resistive construction. The entrance door to such room shall be a Class "B," one and one-half (1 1/2) hour fire rated door.

(G) Ceiling heights shall meet the following requirements:

(i) Storage rooms, patients' toilet rooms, and janitor's closets, closets etc., and other minor rooms shall have ceilings not less than seven feet-eight inches (7' 8") above the finished floor. Ceilings for all other rooms, patient areas, nurse service areas, etc., shall not be less than eight feet-zero inches (8' 0") above the finished floor.

(ii) Ceilings shall be washable or easily cleanable. Non-pervious surface finishes shall be provided in dietary department, soiled utility rooms and bath/shower rooms.

(iii) Ceilings shall be acoustically treated in corridors, patient areas, nurses' stations, nourishment stations, recreation and dining areas.

(H) Boiler rooms, food preparation centers, and laundries shall be insulated and ventilated to maintain comfortable temperature levels on the floor above.

(I) Fire extinguishers shall be provided in recessed locations throughout the building and shall be located not more than five feet-zero inches (5' 0") above the floor.

(J) Floors and walls.

(i) In all areas where floors are subject to wetting, they shall have a nonslip finish.

(ii) Floors shall be easily cleanable.

(iii) Floor materials, threshold, and expansion joint covers shall be flush with each other.

(iv) Walls shall be cleanable and, in the immediate area of plumbing fixtures, the finish shall be moistureproof.

(v) Service pipes in food preparation areas and laundries shall be enclosed.

(vi) Floor and wall penetrations by pipes, ducts and conduits and all joints between floors and walls shall be tightly sealed.

(K) Cubicle curtains and draperies shall be noncombustible or rendered flame retardant.

(L) Windows shall be designed to prevent accidental falls when open.

(M) Mirrors shall be arranged for use by patients in wheelchairs as well as by patients in a standing position.

(N) Soap and paper towels shall be provided at all handwash facilities used by staff.

(O) Prior to licensure of the facility, all electrical and mechanical systems shall be tested, balanced, and operated to demonstrate that the installation and performance of these systems conform to the requirements of the plans and specifications.

(P) Any balcony shall have railings. Such railings shall not be less than forty-eight (48) inches above finished floor.

(20) Required equipment. The following equipment shall be provided by each facility.

(A) one (1) stretcher per nursing unit;

(B) one (1) suction machine per nursing unit;

(C) one (1) oxygen cylinder with transport carrier per nursing unit;

(D) one (1) telephone per nursing unit;

(E) one (1) large, bold-faced clock per nursing unit;

(F) one (1) patient lift per floor;

(G) one (1) ice machine per floor;

(H) one (1) watercooler per floor;

(I) one (1) autoclave per facility; and

(J) one (1) chair or bed scale per facility.

(Effective March 30, 1994)

19-13-D8u. Intravenous therapy programs in chronic and convalescent nursing homes and rest homes with nursing supervision

(a) Definitions

(1) "IV Fluid" shall mean sterile solutions of 50ml or more, intended for intravenous infusion but excluding blood and blood products.

(2) "IV Admixture" shall mean an IV Fluid to which one or more additional drug products have been added.

(3) "IV Therapy" shall mean the introduction of an IV fluid/IV admixture into the blood stream via a vein for the purpose of correcting water deficit and electrolyte imbalances, providing nutrition, and delivering antibiotics and other therapeutic agents approved by the facility's medical staff.

(4) "IV Therapy Program" shall mean the overall plan by which the applying facility will implement, monitor and safeguard the administration of IV therapy to patients.

(5) "Administer" shall mean to initiate the venipuncture and deliver an IV fluid/IV admixture into the blood stream via a vein; and, to monitor, care for the venipuncture site, terminate the procedure, and record pertinent events and observations.

(6) "IV Therapy Nurse" shall mean a registered nurse who is qualified by education and training and has demonstrated proficiency in the theoretical and clinical aspects of IV therapy to administer an IV fluid/admixture.

(b) Intravenous Therapy Program Prohibited; Exceptions. The administration of IV therapy in chronic and convalescent nursing homes and rest homes with nursing supervision is prohibited except when administered directly by a licensed physician or as provided in subsection (c) of this section.

(c) Approved IV Therapy Programs for Chronic and Convalescent Nursing Homes. IV Therapy may be administered in a chronic and convalescent nursing home provided such facility applies for permission from the Commissioner of the Department of Health Services, and such Commissioner or his designee approves the facility's application in accordance with the following requirements:

(1) Each facility which applies for permission to operate an IV therapy program shall submit to the Commissioner a written protocol which shall demonstrate that the program will be developed and implemented in a manner which ensures safe care for all patients receiving IV therapy which shall include at least the following:

(A) A description of the objectives, goals and scope of the IV therapy program;

(B) Names and titles, duties and responsibilities, of persons responsible for the direction, supervision and control of the program. Alternates shall be named in their absences;

(C) Written policies and procedures concerning:

(i) Establishment of the standards of education, training, ongoing supervision, in-service education and evaluation of all personnel in the program including the IV therapy nurses, licensed nursing personnel and supportive nursing personnel;

(ii) The origin, form, content, duration and documentation of physician orders for the IV therapy;

(iii) The safe administration, monitoring, documentation and termination of IV therapy;

(iv) The safe preparation, labeling and handling of IV admixtures;

(v) The procurement, maintenance, and storage of specific types of equipment and solutions which will be used in the program;

(vi) IV therapy related complications, early recognition of the signs and symptoms of sepsis and acute untoward reaction, and appropriate intervention in a timely manner;

(vii) Surveillance, prevention and review of infections associated with IV therapy;

(viii) The ongoing review of the effectiveness and safety of the program to include problem identification, corrective action and documentation of same;

(2) An IV therapy nurse in a chronic and convalescent nursing home operating an approved IV therapy program pursuant to a physician order may:

(A) Initiate a venipuncture in a peripheral vein and deliver an IV Fluid/IV admixture into the blood stream;

(B) Deliver an IV Fluid/IV admixture into a central vein;

(3) Only a physician may initiate and terminate a central vein access.

(4) Licensed nursing personnel may deliver an IV Fluid/IV Admixture into the blood stream via existing lines, monitor, care for the venipuncture site, terminate the procedure, and record pertinent events and observations.

(5) A log shall be maintained of each IV therapy procedures initiated and made available upon the request of the Commissioner. The log shall record as a minimum the following information: Date and time of initiating the IV therapy; name of patient; name of prescriber; description of the IV therapy; date and time of terminating the IV therapy; outcome of the IV therapy; and, complications encountered, if any.

(6) There shall be no changes in the protocol developed pursuant to subdivision (1) of this subsection or modifications in the scope IV therapy as defined in subsection (a) of this section without the written approval of the Commissioner.

(7) Upon determination of compliance with these regulations, approval by the Commissioner to participate in an IV Therapy Program shall be renewed at the time of facility's license renewal. Approval to participate in the program may be revoked at any time for failure to comply with these regulations.

(Effective May 20, 1985)

19-13-D8v. Pharmaceutical services in chronic and convalescent nursing homes and rest homes with nursing supervision

(a) Definitions For the purposes of these regulations:

(1) "Administering" means an act in which a single dose of a prescribed drug or biological is given to a patient by an authorized person in accordance with Federal and State laws and regulations governing such act. The complete act of administration includes removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's order, giving the individual dose to the proper patient, and promptly recording the time and dose given.

(2) "Community Pharmacy" means a pharmacy licensed pursuant to Section 20-168 of the Connecticut General Statutes. An exception may be made for those cases where a specific patient has a third party prescription drug plan which requires the patient to obtain medications from a specific pharmacy located outside the State of Connecticut, provided such pharmacy complies with the requirements of the State of Connecticut regulations and the policy of the facility regarding labeling and packaging.

(3) "Compounding" means the act of selecting, mixing, combining, measuring, counting or otherwise preparing a drug or medicine.

(4) "Dispensing" means those acts of processing a drug for delivery or for administration to a patient pursuant to the order of a practitioner consisting of: The checking of the directions on the label with the directions on the prescription or order to determine accuracy, the selection of the drug from stock to fill the order, the counting, measuring, compounding, or preparation of the drug, the placing of the drug in the proper container, the affixing of the label to the container, and the addition to a written prescription of any required notations. For purposes of this part, it does not include the acts of delivery of a drug to a patient or of administration of the drug to the patient.

(5) "Distributing" means the movement of a legend drug from a community pharmacy or institutional pharmacy to a nursing service area, while in the originally labeled manufacturer's container or in a prepackaged container labeled according to Federal and State statutes and regulations.

(6) "Dose" means the amount of drug to be administered at one time.

(7) "Facility" means a chronic and convalescent nursing home or rest home with nursing supervision.

(8) "Institutional Pharmacy" means that area within a chronic and convalescent nursing home commonly known as the pharmacy, which is under the direct charge of a full-time pharmacist and wherein drugs are stored and regularly compounded or dispensed and the records of such compounding or dispensing maintained, by such pharmacist.

(9) "Legend Drugs" means any article, substance, preparation or device which bears the legend: Federal law prohibits dispensing without a prescription.

(10) "Pharmaceutical Services" means the functions and activities encompassing the procurement, dispensing, distribution, storage and control of all pharmaceuticals used within the facility, and the monitoring of patient drug therapy.

(11) "Pharmacist" means a person duly licensed by the Connecticut Commission of Pharmacy to engage in the practice of pharmacy pursuant to Section 20-170 of the Connecticut General Statutes.

(12) "`PRN' Drug" means a drug which a physician has ordered to be administered only when needed under certain circumstances.

(13) "Practitioner" means a physician, dentist or other person authorized to prescribe drugs in the course of professional service in the State of Connecticut.

(14) "Single Unit" means one, discrete pharmaceutical dosage form (e.g., one tablet or one capsule) of a drug. A single unit becomes a unit dose, if the physician orders that particular amount of a drug.

(15) "Unit Dose" means the ordered amount of a drug in a prepackaged dosage form ready for administration to a particular person by the prescribed route at the prescribed time.

(b) Pharmaceutical services.

(1) Each facility shall assure the availability of pharmaceutical services to meet the needs of the patients. All such pharmaceutical services shall be provided in accordance with all applicable federal and state laws and regulations. Drug distribution and dispensing functions shall be conducted through:

(A) a community pharmacy; or

(B) an institutional pharmacy.

(2) The pharmaceutical services obtained by each facility shall be provided under the supervision of a pharmacist as follows:

(A) If the facility operates an institutional pharmacy, the facility shall employ a pharmacist who shall supervise the provision of pharmaceutical services at least thirty-five (35) hours per week.

(B) When pharmaceutical services are obtained through a community pharmacy, the facility shall have a written agreement with a pharmacist to serve as a consultant on pharmaceutical services, as follows:

(i) The consultant pharmacist shall visit the facility at least monthly, to review the pharmaceutical services provided, make recommendations for improvements thereto and monitor the service to assure the ongoing provision of accurate, efficient and appropriate services.

(ii) Signed dated reports of the pharmacist's monthly reviews, findings and recommendations shall be forwarded to the facility's Administrator, Medical Director and Director of Nursing and kept on file in the facility for a minimum of three (3) years.

(C) Whether pharmaceutical services are obtained through a community pharmacy or an institutional pharmacy, the facility shall ensure that a pharmacist is responsible for the following functions:

(i) compounding, packaging, labeling, dispensing and distributing all drugs to be administered to patients;

(ii) monitoring patient drug therapy for potential drug interactions and incompatibilities at least monthly with documentation of same; and

(iii) inspecting all areas within the facility where drugs (including emergency supplies) are stored at least monthly to assure that all drugs are properly labeled, stored and controlled.

(3) Proper space and equipment shall be provided within the facility for the storage, safeguarding, preparation, dispensing and administration of drugs.

(A) Any storage or medication administration area shall serve clean functions only and shall be well illuminated and ventilated. When any mobile medication cart is not being used in the administration of medicines to patients it shall be stored in a locked room that meets this requirement.

(B) All medication cabinets (stationary or mobile) shall be closed and locked when not in current use unless they are stationary cabinets located in a locked room that serves exclusively for storage of drugs and supplies and equipment used in the administration of drugs.

(C) Controlled substances shall be stored and handled in accordance with provisions set forth in Chapter 420b of the Connecticut General Statutes and regulations thereunder.

(D) When there is an institutional pharmacy:

(i) The premises shall be kept clean, lighted and ventilated, and the equipment and facilities necessary for compounding, manufacturing and dispensing drugs shall be maintained in good operational condition.

(ii) Adequate space shall be provided to allow specialized pharmacy functions such as sterile IV admixture to be performed in discrete areas.

(4) Each facility shall develop, implement and enforce written policies and procedures for control and accountability, distribution, and assurance of quality of all drugs and biologicals, which shall include the following specifics:

(A) Records shall be maintained for all transactions involved in the provision of pharmaceutical services as required by law and as necessary to maintain control of, and accountability for, all drugs and pharmaceutical supplies.

(B) Drugs shall be distributed in the facility in accordance with the following requirements:

(i) All medications shall be dispensed to patients on an individual basis except for predetermined floor stock medication.

(ii) Floor stock shall be limited to emergency drugs, contingency supplies of legend drugs for initiating therapy when the pharmacy is closed, and routinely used non-legend drugs. Floor stock may include controlled substances in facilities that operate an institutional pharmacy.

(iii) Emergency drugs shall be readily available in a designated location.

(C) Drugs and biologicals shall be stored under proper conditions of security, segregation and environmental control at all storage locations.

(i) Drugs shall be accessible only to legally authorized persons and shall be kept in locked storage at any time such a legally authorized person is not in immediate attendance.

(ii) All drugs requiring refrigeration shall be stored separately in a refrigerator that is locked or in a locked room and that is used exclusively for medications and medication adjuncts.

(iii) The inside temperature of a refrigerator in which drugs are stored shall be maintained within a thirty-six degree (36°) to forty-six degree (46°) Fahrenheit range.

(D) All drugs shall be kept in containers that have been labeled by a pharmacist or in their original containers labeled by their manufacturer

and shall not be transferred from the containers in which they were obtained except for preparation of a dose for administration. Drugs to be dispensed to patients on leaves of absence or at the time of discharge from the facility shall be packaged in accordance with the provisions of the Federal Poison Prevention Act and any other applicable Federal or State Law.

(E) Drugs and biologicals shall be properly labeled as follows:

(i) Floor stock containers shall be labeled at least with the following information: name and strength of drug; manufacturer's lot number or internal control number; and, expiration date.

(ii) The label for containers of medication dispensed from an institutional pharmacy for inpatient use shall include at least the following information: name of the patient; name of prescribing practitioner; name, strength and quantity of drug dispensed; expiration date.

(iii) The label for containers of medication obtained from a community pharmacy for inpatient use shall include at least the following information: name, address and telephone number of the dispensing pharmacy; name of the patient; name of the prescribing practitioner; name, strength and quantity of drug dispensed, date of dispensing the medication; expiration date. Specific directions for use must be included in the labeling of prescriptions containing controlled substances.

(iv) The label for containers of medication dispensed to patients for inpatient self care use, or during leaves of absence or at discharge from the facility shall include at least the following information: name, address and telephone number of the dispensing pharmacy; name of the patient; name of the prescribing practitioner; specific directions for use; name, strength and quantity of the drug dispensed; date of dispensing.

(v) In cases where a multiple dose package is too small to accommodate a standard prescription label, the standard label may be placed on an outer container into which the multiple dose package is placed. A reference label containing the name of the patient, prescription serial number and the name and strength of the drug shall be attached to the actual multiple dose package. Injectables intended for single dose that are ordered in a multiple quantity may be banded together for dispensing and one (1) label placed on the outside of the banded package.

(vi) In lieu of explicitly stated expiration dating on the prescription container label, a system established by facility policy may be used for controlling the expiration dating of time-dated drugs.

(F) Drugs on the premises of the facility which are outdated, visibly deteriorated, unlabeled, inadequately labeled, discontinued, or obsolete shall be disposed of in accordance with the following requirements:

(i) Controlled substances shall be disposed of in accordance with Section 21a-262-3 of the regulations of Connecticut State Agencies.

(ii) Non-controlled substances shall be destroyed on the premises by a licensed nurse or pharmacist in the presence of another staff person, in a safe manner so as to render the drugs non-recoverable. The facility shall maintain a record of any such destructions which shall include as a minimum the following information: date, strength, form and quantity of drugs destroyed; and the signatures of the persons destroying the drugs and witnessing the destruction.

(iii) Records for the destruction of drugs shall be kept on file for three (3) years.

(G) Current pharmaceutical reference material shall be kept on the premises in order to provide the professional staff with complete information concerning drugs.

(H) The following additional requirements shall apply to any unit dose drug distribution system:

(i) Each single unit or unit dose of a drug shall be packaged in a manner that protects the drug from contamination or deterioration and prevents release of the drug until the time the package is opened deliberately.

(ii) A clear, legible label shall be printed on or affixed securely to each package of a single unit or unit dose of a drug. Each drug label shall include the name; strength; for each unit dose package, the dosage amount of the drug; the lot or control number; and the expiration date for any time-dated drugs.

(iii) Packages of single unit or unit doses of drugs shall be placed, transported and kept in individual compartments.

(iv) Each individual drug compartment shall be labeled with the full name of the patient, and the patient's room number or bed number.

(I) The facility shall implement a drug recall procedure which can be readily implemented.

(5) Each facility shall develop and follow current written policies and procedures for the safe prescribing and administration of drugs.

(A) Medication orders shall be explicit as to drug, dose, route, frequency, and if P.R.N., reason for use.

(i) Medications not specifically limited as to time or number of doses shall be stopped in accordance with the following time frame: controlled substances shall be stopped within three (3) days; antibiotics and other antiinfectives (topical and systemic), anti-coagulants, antiemetics, cortico steroids (topical and systemic), cough and cold preparations, and psychotherapeutic agents shall be stopped within ten (10) days.

(ii) Orders for all other drugs shall remain in effect until the time of the next scheduled visit of the physician.

(iii) A staff member shall notify the practitioner of the impending stop order prior to the time the drug would be automatically stopped in accordance with the preceding policy.

(B) Patients shall be permitted to self-administer medications on a specific written order from the physician. Self-administered medication shall be monitored and controlled in accordance with procedures established in the facility.

(C) Medication errors and apparent adverse drug reactions shall be recorded in the patient's medical record, reported to the attending physician, director of nursing, and consultant pharmacist, as appropriate, and described in a full incident report in accordance with Section 19-13-D8t (g) of the Regulations of Connecticut State Agencies.

(6) A pharmacy and therapeutics committee shall oversee the pharmaceutical services provided to each facility, make recommendations for improvement thereto, and monitor the service to ensure its accuracy and adequacy.

(A) The committee shall be composed of at least one pharmacist, the facility's director of nursing, the facility's administrator, and a physician.

(B) The committee shall meet, at least quarterly, and document its activities, findings and recommendations.

(C) Specific functions of the committee shall, as a minimum, include the following:
(i) Developing procedures for the distribution and control of drugs and biologicals in the facility in accordance with these regulations;
(ii) Reviewing adverse drug reactions that occur in the facility and reporting clinically significant incidents to the Federal Food and Drug Administration; and
(iii) Reviewing medication errors that occur in the facility and recommending appropriate action to minimize the recurrence of such incidents.

(Effective March 30, 1994)

19-13-D9. Chronic and convalescent nursing homes and rest homes with nursing supervision with authorization to care for persons with manageable psychiatric conditions as determined by a board qualified or certified psychiatrist

Chronic and convalescent nursing homes licensed under section 19-13-D8 and rest homes with nursing supervision licensed under section 19-13-D7 may be authorized to care for persons with manageable psychiatric conditions as determined by a board qualified or certified psychiatrist, provided they shall comply with the requirements of section 19-13-D13.

(Effective December 8, 1975.)

19-13-D12. Multi-care institutions

Each unit of a multi-care institution conforming to the definition of any institution listed in section 19-13-D1 shall be required to meet the regulations governing the maintenance and operation of such institution as specified in this regulation.

19-13-D13. Chronic and convalescent nursing homes and rest homes with nursing supervision with authorization to care for persons with manageable psychiatric conditions as determined by a board qualified or certified psychiatrist

Chronic and convalescent nursing homes and rest homes with nursing supervision licensed under section 19-33 of the general statutes complying with this section may be authorized to accept persons suffering from manageable psychiatric conditions as determined by a board qualified or certified psychiatrist when such persons have been evaluated by a physician licensed to practice medicine and surgery in Connecticut who has completed graduate residency training approved by the American Board of Psychiatry and Neurology and when this physician has recommended in writing that the person may be appropriately cared for in the nursing home:

(a) In all chronic and convalescent nursing homes of any size and rest homes with nursing supervision of sixty one beds or more there shall be in attendance at all times a registered nurse, or a nurse with special training or experience in the care of mental patients. In rest homes with nursing supervision of sixty beds or less the registered nurse or a nurse with special training or experience in the care of mental patients may be a consultant. Consultation shall be at least eight hours per week.

(b) A person suffering from a manageable psychiatric condition as determined by a qualified psychiatrist may be admitted to such a nursing home or rest home with nursing supervision only on a written certificate. Such certificate shall give the name and location of the nursing home or rest home with nursing supervision to which admission is sought, the name and address of the person in charge, the name, age, sex and residence of the patient, he name and address of a responsible relative or guardian, the diagnosis of the mental condition according to standard classified nomenclature of mental disease, the prognosis of the case and previous admissions to psychiatric hospitals and shall express the opinion that the patient may be cared for in such nursing home without injury to the

patient or persons or property. These certificates shall be kept in a manner approved by the commissioner of health.

(c) The following rules apply to the care of patients:

(1) Patients shall be treated kindly at all times.

(2) No patient shall be restrained, either by physical or chemical means, except on written order of a physician. Should such physical or chemical restraint be required, the physician shall record in the patient's clinical record the order for such restraint and the reason that such restraint is required as well as the suitability of the patient for continued stay in a chronic and convalescent nursing home or a rest home with nursing supervision. The physician shall be required to renew the order for such restraint and to indicate the reason for such restraint at least every ten days. The nursing staff shall be required to record all physical restraints used by type, frequency of use and each time they are checked to ensure the patient's health and safety are not being jeopardized. Licensed nurses may use physical restraints to protect the patient, or others in the institution, if such nurse or nurses deem that this action is necessary. This action may be done without a physician's order providing that the physician is notified as soon as the patient is safely under control and the physician shall visit the institution to take appropriate action in regard to the nurse's decision within eight hours of the notification.

(3) If a patient's condition changes so that he may do injury to himself, other persons or property, arrangement shall be made for his immediate transfer to a more suitable institution.

(4) No patient may be held contrary to the commitment laws of Connecticut.

(d) Classification of civil penalty violation for chronic and convalescent nursing homes and rest homes with nursing supervision with authorization to care for persons with manageable psychiatric condition as determined by a board qualified or certified psychiatrist. Any chronic and convalescent nursing home or rest home with nursing supervision with authorization to care for persons with manageable psychiatric conditions as determined by a board qualified or certified psychiatrist as defined in Section 19a-521 Connecticut General Statutes found by the Commissioner of Health Services to be in violation of one of the following provisions of the Regulations of the Connecticut State Agencies known as the Public Health Code shall be subject to the class of violation indicated below and penalties indicated in Section 19a-527 Connecticut General Statutes:

(1) A violation of the following provisions shall result in a Class B violation:

(A) 19-13-D13 (b);

(B) 19-13-D13 (c) (2);

(Effective March 1, 1988.)