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CHAPTER IV

Hospitals, Child Day Care Centers, Other Institutions and Children's General Hospitals

Sec. 19-13-D1. Institutions, classifications and definitions

Institutions licensed under sections 19a-490 to 19a-503 inclusive and 19a-507a(3) of the Connecticut General Statutes, as amended, are classified and defined as follows:

(a) **Classifications.**

(1) *Short-term hospitals:

(A) General; Children's general hospitals;

(B) special;

(2) *Long-term hospitals:

(A) Chronic disease;

(3) other institutions:

(A) Residential care homes;

(B) rest homes with nursing supervision;

(C) chronic and convalescent nursing homes;

(D) multi-care institutions;

(E) infirmaries operated by educational institutions for the care by a licensed physician or licensed osteopath of students enrolled in, and faculty and employees, of such institutions;

(F) industrial health facilities;

(G) private freestanding mental health day treatment facilities for adults;

(H) private freestanding mental health intermediate treatment facilities for adults;

(I) private freestanding mental health psychiatric outpatient clinics for adults;

(J) private freestanding mental health residential living centers;

(K) private freestanding community residences;

(L) private freestanding facilities for the care or treatment of substance abusive or dependent persons.

(b) **Definitions:**

(1) short-term hospitals:

(A) General Hospital - a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries; Children's general hospital - a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions among children, including injuries;

(B) Special hospital - a short-term hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a limited special group of acute conditions;

(C) Hospice - A short-term hospital having facilities, medical staff and necessary personnel to provide medical, palliative, psychological, spiritual, and supportive care and treatment for the terminally ill and their families including outpatient care and services, home based care and services and bereavement services;

(2) Long-term hospitals: chronic disease hospital - a long-term hospital having facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of a wide range of chronic diseases;

*Short-term and long-term classified by average length of stay (under or over thirty days).

(3) Other institutions:

(A) Residential care home-an institution having facilities and all necessary personnel to furnish food, shelter and laundry for two or more persons unrelated to the proprietor and in addition, providing services of a personal nature which do not require the training or skills of a licensed nurse. Additional services of a personal nature may include assistance with bathing, help with dressing, preparation of special diets and supervision over medications which are self-administered;

(B) Rest home with nursing supervision - an institution having facilities and all necessary personnel to provide, in addition to personal care required in a home for the aged, nursing supervision under medical director twenty-four hours per day;

(C) Chronic and convalescent nursing home - a long-term institution having facilities and all necessary personnel to provide skilled nursing care under medical supervision and direction to carry out simple, non-surgical treatment and dietary procedures for chronic diseases, or convalescent stages of acute diseases or injuries;

(D) Multi-care institutions - an institution owned and operated by the same licensee having in single or multiple facilities segregated units each of which are devoted to a complexity of patient care defined in this subsection;

(E) Infirmary - a health care facility operated by an educational institution, which provides evaluation and treatment services for routine health problems and provides overnight accommodations of limited duration for students, faculty and employees of such institution who are receiving short term care and treatment for noncritical illnesses, are recovering from surgery, or require observation, and who do not require the skills and equipment of an acute hospital;

(F) Industrial health facility - a facility established, conducted, operated or maintained by a commercial or industrial establishment primarily for the ambulatory care of its employees where health services in addition to first aid are provided. First aid means emergency treatment given by a non-medical person until medical aid is obtained;

(G) Private freestanding mental health day treatment facility - a facility providing evaluation, diagnosis, and ambulatory treatment services for individuals who are experiencing mental, emotional or behavioral problems, disturbances, dysfunctions or disorders as defined in the most recent edition of the diagnostic and statistical manual of the American Psychiatric Association as it may be revised from time to time and whose unit of service to each client is a minimum of four hours and a maximum of twelve hours;

(H) Private freestanding mental health intermediate treatment facility for adults - a facility providing evaluative, diagnostic, and treatment services in a residential setting for individuals who are experiencing mental, emotional or behavioral problems, disturbances, dysfunctions or disorders as defined in the most recent edition of the diagnostic and statistical manual of the American Psychiatric Association, as it may be revised from time to time, which do not require a hospital level of treatment;

(I) Private freestanding mental health psychiatric outpatient clinic for adults - a facility providing evaluation, diagnosis, and ambulatory treatment, to individuals who have mental, emotional or behavioral problems, disturbances, dysfunctions or disorders as defined in the most recent edition of the diagnostic and statistical manual of the American Psychiatric Association, as it may be revised from time to time;

(J) Private freestanding mental health residential living center - a facility providing a supervised, structured and supportive group living arrangement which includes

psychosocial rehabilitation services and may also provide assistance in obtaining necessary community services to persons in need of mental health services;

(K) Private freestanding community residence - a residence for up to eight mentally ill adults as defined in section 19a-507a(3) of the Connecticut General Statutes;

(L) Private freestanding facility for the care or treatment of substance abusive or dependent persons - a facility providing either ambulatory chemical detoxification treatment, or care and rehabilitation, or chemical maintenance treatment, or day or evening treatment, or intensive treatment, or intermediate and long term treatment, or medical triage, or outpatient treatment or residential detoxification and evaluation to substance abusive or dependent persons.

(Effective September 25, 1990; amended September 13, 2001)

Sec. 19-13-D1a. Deemed status

(a) Any institution as defined by sections 19-576 (b) through 19-576 (f) of the Connecticut General Statutes may apply to the department of health services to be deemed licensable without additional inspection or investigation if said institution:

(1) Has been certified as a provider of services by the United States Department of Health and Human Services within the immediately preceding 12 month period, except that with respect to institutions defined in subsection 19-576 (b) of the Connecticut General Statutes, the institution need only be currently so certified;

(2) Has not been denied a license or renewal thereof or has not had a condition of participation found to be out of compliance at any time during the three years immediately preceding such application;

(3) Has been inspected and investigated pursuant to ordinary license renewal procedures at least once in the immediately preceding four years and no less than a total of two times;

(4) Has agreed to allow the department of health services to inspect and review any reports issued by the reviewing or accrediting agency or by the subject institution related to the subject institution concerning certification as a provider by the department of health and human services; and

(5) With respect to institutions as defined in subsections (c), (d), (e) and (f) of section 19-576 of the Connecticut General Statutes, has not experienced a change in the personnel serving as chief administrative officer or licensed administrator, medical director, or director of nurses since the date of the immediately preceding department of health and human services provider survey.

(b) Applications for deemed status shall be on forms provided by the department and shall contain sufficient documentation to establish the satisfaction of the conditions set forth in subsection (a) hereof.

(c) In addition to the review of all material submitted in support of an application for deemed status, the department of health services may take the following actions or consider the following facts and circumstances in granting or denying said application:

(1) Joint inspections with certifying agencies or direct observation of certification procedures;

(2) Verification of compliance with Public Health Code standards not included in the federal conditions of participation;

(3) Review of departmental records or records of any other state department relating to accidents, incidents, complaints, and periodic reports;

(4) With respect to institutions as defined in subsection (b) of section 19-576 of the Connecticut General Statutes, whether such institution has experienced a change in its chief executive officer.

(d) If the applicant fully complies with the conditions set forth in section (a) and department of health services validation does not provide a basis for denial, the department shall grant the application for deemed status, and the license renewal for such institution shall be issued without further inspection or verification.

(e) Nothing contained in these regulations shall be interpreted or applied so as to limit or interfere with the right and duty of the department of health services to enforce the Public Health Code as provided by law.

(Effective April 24, 1981)

Sec. 19-13-D2. Operation and maintenance

All hospitals licensed under sections 19-32 to 19-42 of the general statutes, as amended, shall comply with the requirements set forth in sections 19-13-D2 to 19-13-D12, inclusive, before a license is issued.

Sec. 19-13-D3. Short-term hospitals, general and special

(a) Physical plant.

(1) The hospital buildings shall be of sound construction and shall provide adequate space and equipment for patient accommodations and for service and other areas, in accordance with the requirements of the Department of Public Health. Properly equipped diagnostic and therapeutic facilities shall be provided.

(2) The hospital buildings and equipment shall meet the requirements of the most current Fire Safety Code pursuant to section 29-292 of the Connecticut General Statutes. Annually, the licensee shall submit a current certificate of inspection by the local fire marshal to the Department of Public Health.

(3) Areas in which explosive gases are used, and areas in which radioactive materials are used, shall meet the requirements of the Department of Public Health for adequate protection of patients and personnel.

(4) The hospital buildings and equipment shall be maintained in a good state of repair and shall be kept clean at all times.

(5) Each hospital that provides maternity service shall have appropriate space available and equipment for labor, delivery, recovery and post-partum care. The hospital may configure the physical space and composition of maternity service through:

(A) traditional obstetrical components (various rooms and locations used for each patient); or,

(B) labor/delivery/delivery units (birthing room with separate post-partum care); or,

(C) labor/delivery, recovery/post-partum units (single room); or,

(D) a combination of the configurations listed in subparagraphs (A) to (C) inclusive of this subdivision.

(b) Administration.

(1) The hospital shall be managed by a governing board whose duties shall include, as a minimum:

(A) Adoption of bylaws, rules and regulations, including medical staff bylaws;

(B) annual or biennial appointment of the medical staff;

(C) appointment of a competent hospital administrator who shall be qualified as a result of either (i) the completion of a Master's level or doctoral level degree and at least three years of experience in hospital management or administration, or (ii) at least five years in hospital management or administration. These requirements

shall not apply to an administrator already in place as of the effective date of this regulation.

(2) The administrator shall be responsible to the governing board for the management and operation of the hospital and for the employment of personnel. The administrator may attend meetings of the governing board and meetings of the medical staff.

(3) Personnel shall be employed in sufficient numbers and of adequate qualifications that the functions of the hospital may be performed efficiently.

(c) **Medical staff.**

(1) There shall be an organized medical staff of not fewer than five physicians, one of whom shall serve as a chief or president of the medical staff.

(2) The medical staff shall adopt written rules and regulations governing its own activities, subject to approval by the governing board of the hospital. As a minimum, these shall include:

- (A) Method of control of privileges granted to members of the medical staff;
- (B) method of control of clinical work;
- (C) provision for regular staff conferences;
- (D) appointment of a medical executive committee, or its equivalent, and other committees as appropriate;
- (E) procedure for recommending appointments to the medical staff and for hearing complaints regarding the conduct of members and referring the same, with recommendations, to the governing board.

(3) Medical staff conferences shall be held at least once each quarter, either as general medical staff meetings or through departments. Minutes and a record of attendance shall be kept for each such meeting.

(4) Each hospital shall have, as a minimum, the following departments: medicine, pathology and radiology. Hospitals may operate other departments. If surgery or obstetrics is performed in the hospital, there shall be a department of anesthesia. If a hospital operates departments in surgery, obstetrics, psychiatry, or anesthesia, each such department shall have a chief.

(A) Each chief shall be a licensed physician; responsible for supervising the overall quality of his department; and qualified on the basis of postgraduate education, equivalent training, or Board certification in the area for which the licensed physician is chief.

(B) If there is a maternity service or if there are eight hundred or more children under age twelve admitted to the hospital annually, there shall be a department of pediatrics to include on the active staff at least two physicians who have completed a residency training program approved by either the American Board of Pediatrics or the American Board of Family Medicine and one such physician shall be designated chief of that service.

(5) Psychiatric services. There shall be at least one registered nurse or licensed practical nurse with specialized psychiatric experience and training on duty at all times on the service. There shall be available a licensed clinical social worker, a registered nurse and at least one additional staff person who is qualified by education and professional discipline to assess and develop care plan interventions pertinent to the individual patient's needs.

(d) **Medical records.**

(1) There shall be a medical record department with adequate space, equipment and qualified personnel, including a records manager or director who possesses sufficient training and experience to oversee the medical records department.

(2) A medical record shall be started for each patient at the time of admission with complete identification data and a nurse's or other licensed practitioner's notation of condition on admission. Upon admission, an admission note and orders of the attending or admitting physician shall be added to the medical record. The medical record of every patient shall contain a complete history and physical examination which, except in emergencies, shall have been completed no more than seven days prior to admission or within forty-eight hours after admission. This requirement is satisfied if a history and physical examination was performed within thirty days prior to the admission and updated no more than seven days prior to, or within forty-eight hours after, the admission. The recording of the history and physical examination shall be, except in emergencies, placed in the record prior to any surgery and within the timeframe set forth in the hospital's policies in all other cases.

(3) All medical records shall include proper identification data; the clinical records shall be prepared accurately and completed promptly and shall include sufficient information including progress notes to justify the diagnosis and warrant the treatment; doctor's orders, nurse's notes and all entries shall be signed or initialed by the person making the entry. The medical records created or maintained by a hospital do not have to comply with the requirements of section 19a-14-40 to 19a-14-44, inclusive, of the Regulations of Connecticut State Agencies.

(4) If obstetrics is performed, a complete record of each case shall be kept which shall include such items of information as may be required by the Commissioner of Public Health and shall include all items necessary to fill out a death certificate for the mother and all items necessary to fill out a birth certificate or a death certificate for the baby.

(5) With respect to obstetrics, attending physicians shall provide to the hospital an adequate summary of the patient's office prenatal record or a copy of the prenatal record by the time of admission or, in the case of a precipitous admission, as soon as practicable thereafter.

(6) Medical records shall be filed in an accessible manner and shall be kept for a minimum of ten years after discharge of patients, except that original medical records may be destroyed sooner if they are preserved by a process consistent with current hospital industry standards. The hospital shall provide the Department of Public Health with a list of the process or processes it uses.

(7) Medical records shall be completed within thirty days after discharge of the patient except in unusual circumstances which shall be specified in the medical staff rules and regulations. One of these specified circumstances shall be that the hospital discharge summary shall be completed and shall accompany patients at the time of discharge to another health care facility. Persistent failure by a physician to maintain proper records of his patients, promptly prepared and completed, shall constitute grounds for disciplinary action with respect to medical staff privileges.

(8) Informed consent. It shall be the responsibility of each hospital to assure that the bylaws or rules and regulations of the medical staff include the requirement that, except in emergency situations, the responsible physician shall obtain proper informed consent as a prerequisite to any procedure or treatment for which it is appropriate and provide evidence of consent by a form signed by the patient or a

written statement signed by the physician on the patient's hospital record. The extent of information to be supplied by the physician to the patient shall include the specific procedure or treatment, or both, the reasonably foreseeable risks, and reasonable alternatives for care or treatment.

(9) In addition to record requirements specified for general hospitals, the medical records for psychiatric patients shall also include an examination that shall be recorded not more than sixty hours after admitting the patient.

(e) **Nursing service.**

(1) There shall be a competent nurse, licensed in Connecticut, as director of nursing service or an equivalent position, who shall be responsible to the administrator for nursing service in the hospital.

(2) The ratio of patients to registered nurses on duty throughout the hospital shall at no time exceed twenty-five patients or fraction thereof to one registered nurse.

(3) The ratio of patients to all nursing staff, registered nurses, licensed practical nurses and other nursing attendants on duty in the hospital shall not exceed seven patients, or fraction thereof, to one from 7 a.m. to 7 p.m., and fifteen patients, or fraction thereof, to one from 7 p.m. to 7 a.m.

(4) If there is an in-patient obstetrical department, the following shall apply:

(A) The ratio of all nursing staff to patients for obstetrical services shall be no less than one nurse to each ten patients, or fraction thereof, on the 7am to 3pm shift; no less than one nurse to each fifteen patients, or fraction thereof, on the 3pm to 11pm shift; and no less than one nurse to each twenty patients, or fraction thereof, on the 11pm to 7 am shift;

(B) there shall be at least one registered nurse on duty at all times. For obstetrical services with a census of twenty or more patients, there shall also be a registered nurse on duty for overall supervision of the unit;

(C) these ratios shall be calculated without inclusion of newborns or pediatric patients.

(f) **Diagnostic and therapeutic facilities.** The hospital shall maintain or have available facilities, equipment and qualified personnel, under competent medical supervision, appropriate to the needs of the hospital in serving its patients. These shall include, as a minimum, a clinical laboratory, blood bank, pathological services, a radiology department and an operating room.

(g) **Pharmacy.**

(1) There shall be a competent pharmacist, licensed in Connecticut, who shall be responsible to the administrator for all pharmaceutical services in the hospital. In general and special hospitals of one hundred beds or more, he shall serve on a full-time basis.

(2) The hospital pharmacy shall be operated in compliance with all applicable state and federal drug laws and regulations.

(3) The premises shall be kept clean, adequately lighted, and ventilated and the equipment and facilities appropriate for compounding, dispensing, manufacturing, producing or processing of drugs shall be maintained in good order.

(4) Drugs used in the hospital shall meet standards established by the United States Pharmacopoeia, The National Formulary or the Federal Food and Drug Administration and shall be stored and kept so as to insure their proper purity and strength. A medical staff pharmacy committee in conference with the pharmacist shall formulate policies to control the administration of drugs. All drugs, disinfecting

solution and other preparations shall be distinctly and correctly labeled and kept readily available in a location approved by the Commissioner of Public Health.

(h) Dietary service.

(1) Adequate space, equipment and qualified personnel shall be provided to ensure proper selection, storage, preparation and serving of regular and special diets to patients at regularly scheduled hours.

(2) Menus shall be prepared and shall meet basic nutritional needs.

(3) Methods of dishwashing and sanitizing, food handling and garbage disposal shall comply with the requirements of the Department of Public Health.

(i) General.

(1) The hospital shall have an adequate laundry service.

(2) Adequate housekeeping and maintenance services shall be provided.

(3) Proper heat, hot water, lighting and ventilation shall be maintained at all times.

(4) There shall be a system of communication sufficient to meet the needs of the hospital.

(5) Periodic licensure inspection shall be for the purpose of verifying that a hospital is in compliance with state requirements for licensure. The inspection focuses on, but is not limited to, the performance of the facility since the prior licensure inspection. Additional inspections shall be performed as necessary to address specific concerns or complaints relating to hospital performance or patient care. Any article which presents evidence of any crime being committed therein may be removed and delivered to the appropriate law enforcement official or the state agency having jurisdiction according to law.

(6) The management, personnel, equipment, facilities, sanitation and maintenance of the hospital shall be such as reasonably to ensure the health, comfort and safety of the patients at all times.

(7) When a patient appears to have ceased all vital bodily functions irreversibly, the body shall be moved promptly to an otherwise unoccupied room in the same institution pending pronouncement of death pursuant to section 7-62b of the Connecticut General Statutes. The facility shall make available a room which will provide for the dignified holding of the body of the deceased person, where it will not be exposed to the view of patients or visitors. The room so designated may be used for other purposes when not required for this purpose.

(8) Services may be furnished under contract, including but not limited to shared services.

(j) Emergencies.

(1) Provision shall be made to maintain essential services during disaster and similar emergency situations.

(2) Each general hospital shall be organized in such a way as to provide adequate care for persons with acute emergencies at all hours.

(3) In a city or town with two or more hospitals, the operation by one such hospital, under a mutual agreement, acceptable to the Connecticut Department of Public Health, of an emergency room twenty-four hours a day shall be considered satisfactory compliance with this section; in other hospitals arrangements shall be made to operate an emergency room twenty-four hours a day with a physician to be available within twenty minutes of the call to the physician.

(k) Maternity service. The following procedures shall be carried out for each case admitted to a maternity service.

(1) For each maternity patient, her attending physician shall provide to the hospital a statement of compliance with Section 19a-90 of the Connecticut General Statutes.

(2) Before removal from the delivery room, each newborn infant shall be marked using an appropriate identification method which shall remain with the child at all times while the child is in the hospital.

(3) Subject to the exceptions provided in Section 19a-219 of the Connecticut General Statutes, the physician in attendance at the birth of any infant, or the physician's designated agent, shall instill into the eyes of such infant, immediately after birth, one or two drops of a prophylactic solution approved by the Department of Public Health for the purpose of preventing inflammation of the eyes of the newborn.

(4) Any indication of postpartum maternity infection shall be reported immediately to the physician responsible for the care of the patient, and in addition, to the physician responsible for the care of the newborn infant of such maternity patient. Any obstetrical patient with any infection which may be contagious shall be isolated from other maternity patients. Any infant showing evidence of infection of any kind or any infant exposed to an infected mother shall be isolated from other infants, in a manner approved by the Commissioner of Public Health.

(I) **Infection control.** The hospital shall provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There shall be an active program for the surveillance, prevention, control and investigation of infections and communicable diseases.

(1) The hospital shall designate a person or persons as infection control officer(s) who is a physician, or an individual qualified in infection control through education or experience to develop and implement policies governing control of infections and communicable diseases:

(A) The infection control officer(s) shall develop a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel;

(B) The infection control officer(s) shall maintain a log of incidents related to infections and communicable diseases.

(2) The infection control officer(s), in conjunction with the hospital administrator, medical staff, and director of nursing, shall:

(A) ensure that the hospital-wide quality assurance program and training programs address problems identified by the infection control officer(s); and

(B) be responsible for the implementation of corrective action plans in identified problem areas.

(3) The infection control program shall hold monthly meetings, chaired by a physician qualified in and with a special interest in infection control to:

(A) review information obtained from day-to-day surveillance activities of the program;

(B) review and revise existing standards; and

(C) report to the medical executive committee and/or other hospital committees as appropriate about its activities.

(4) The minutes of the meetings shall document the review and evaluation of the data and the development and revision of measures for control of infection. These records shall be available to the State Department of Public Health for review.

(Effective March 19, 1987; amended March 30, 2004, August 3, 2007)

Sec. 19-13-D4.

Repealed, July 26, 1973.

Sec. 19-13-D4a. Short-term hospitals, Children's General

(a) **Physical plant.** (1) The hospital buildings shall be of sound construction and shall provide adequate space and equipment for patient accommodations and for service and other areas, in accordance with the requirements of the state department of health. Properly equipped diagnostic and therapeutic facilities shall be provided. (2) The hospital buildings and equipment shall meet the requirements of the state fire safety code. (Reg. 29-40-1 et seq.) Annual application for a license shall be accompanied by a certificate of inspection by the local fire marshal. (3) Areas in which explosive gases are used, and areas in which radioactive materials are used, shall meet the requirements of the state department of health for adequate protection

of patients and personnel. (4) The hospital buildings and equipment shall be maintained in a good state of repair and shall be kept clean at all times.

(b) **Administration.** (1) The hospital shall be managed by a governing board whose duties shall include, as a minimum: (A) Adoption of bylaws, rules and regulations, including medical staff bylaws; (B) annual appointment of the medical staff; (C) appointment of an administrator who shall be qualified as a result of the completion of postgraduate training approved by the Association of University Programs in Hospital Administration or three years experience as an assistant administrator under an administrator whose qualifications for such training are approved by the public health council; (D) establishment of a joint conference committee composed of an equal number of representatives of the governing board and of the medical staff, and the administrator of the hospital. (2) The administrator shall be responsible to the governing board for the management and operation of the hospital and for the employment of personnel. He shall attend meetings of the governing board and meetings of the medical staff and shall be a member of the joint conference committee. (3) Personnel shall be employed in sufficient numbers and of adequate qualifications that the functions of the hospital may be performed efficiently.

(c) **Medical staff.** (1) There shall be an organized medical staff of not fewer than five physicians, one of whom shall serve as a chief or president of the medical staff. (2) The medical staff shall adopt written rules and regulations governing its own activities, subject to approval by the governing board of the hospital. As a minimum, these shall include: (A) Method of control of privileges granted to members of the medical staff; (B) method of control of clinical work; (C) provision for regular staff conferences; (D) regulations for preparation of medical records; (E) appointment of committees to include medical record committee (or medical audit committee), representatives to joint conference committee and others as necessary; (F) procedures for recommending appointments to the medical staff and for hearing complaints regarding the conduct of members and referring the same, with recommendations, to the governing board. (3) Medical staff conferences shall be held once each month or more frequently. If all clinical groups hold departmental conferences at least monthly, general staff conferences may be less frequent but there shall be a minimum of four each year, and each physician on the active staff shall be required to attend a minimum of ten departmental or general staff meetings or a combination thereof each year. Conferences shall be planned to implement improved service to patients and shall be devoted primarily to thorough review and analysis of clinical work and discussion of interesting cases. All meetings shall be attended by at least fifty percent of the active staff members. Minutes and a record of attendance shall be kept. (4) Qualifications of certain department heads: (A) If surgery is performed in the hospital, there shall be a department of surgery under the overall direction of a chief who shall be responsible for supervising the quality of all surgical procedures performed. Such chief shall be a physician qualified on the basis of postgraduate approved training or equivalent experience or a combination of both; (B) if surgery is performed, there shall be a department of anesthesiology under the overall direction of a chief who shall be responsible for supervising the adequacy of anesthesia given. Such chief shall be a physician qualified on the basis of approved postgraduate training or equivalent experience or a combination of both; (C) there shall be departments of pathology, pediatrics and radiology, each of which will be under the overall direction of a chief who shall be responsible for supervising the quality of service given. Such chief shall be a physician qualified on the basis of postgraduate approved training or experience, or a combination of both; (D) Psychiatric services:

When there is an inpatient psychiatric service there shall be a department of psychiatry under the overall supervision of a chief who shall be a physician qualified on the basis of certification by the American Board of Psychiatry or with sufficient postgraduate psychiatric residency training or experience or combination thereof to be eligible to take the examinations of that board. In addition to record requirements specified for general hospitals, the medical records for psychiatric patients shall also include a psychiatric examination recorded within seven days of admission of the patient. The ratio of registered nurses and other nursing personnel on duty shall conform to the requirements in the rest of the hospital, provided where possible there shall be at least one nurse with specialized psychiatric experience and provided there shall not be less than one registered nurse or one licensed practical nurse on duty at all times on the service. If the nurse in charge is a licensed practical nurse, such nurse shall have had specialized psychiatric training. There shall be available a qualified social worker, a qualified psychologist and at least one activity worker, preferably a registered occupational therapist wherever possible. Statistical reports of psychiatric admissions and discharges and any sudden deaths shall be made to the department of mental health.

(d) Medical records.

(1) There shall be a medical record department with adequate space, equipment and qualified personnel, to include at least one registered record librarian or a person with equivalent training and experience, in a hospital of one hundred beds or over.

(2) A medical record shall be started for each patient at the time of admission with complete identification data and a nurse's notation of condition on admission. To this shall be added immediately an admission note and orders by the attending or a resident physician. A complete history and physical examination shall be recorded by the physician within twenty-four hours of admission and always before surgery, except in cases of unusual emergency.

(3) All medical records shall include proper identification data; the clinical records shall be prepared accurately and completed promptly by the physicians and shall include sufficient information to justify the diagnosis and warrant the treatment; doctor's orders, nurse's notes and charts shall be kept current in an acceptable manner; all entries shall be signed by the person responsible for them.

(4) Medical records other than nurse's notes shall be filed in an accessible manner in the hospital and shall be kept for a minimum of twenty-five years after discharge of patients, except that original medical records may be destroyed sooner if they are microfilmed by a process approved by the state department of health.

(5) Medical records shall be completed within thirty days after discharge of the patient except in unusual circumstances which shall be specified in the medical staff rules and regulations. Persistent failure by a physician to maintain proper records of his patients, promptly prepared and completed, shall constitute grounds for suspending or withdrawing his medical staff privileges.

(6) For patients transferred to a nursing home a transcript of the medical examination and a summary of significant laboratory and x-ray findings, diagnosis and suggested treatment shall accompany the patient.

(e) Nursing service. (1) There shall be a competent nurse as director of nursing service, registered in Connecticut, with specialized training or experience in pediatric nursing, who shall be responsible to the administrator for nursing service in the hospital. (2) The ratio of patients to registered nurses on duty on an individual nursing unit shall be one to twenty patients or fraction thereof. (3) The ratio of patients to all nursing staff, registered nurses, licensed practical nurses and other

nursing attendants on duty in the hospital shall not exceed seven patients, or fraction thereof, to one from 7 a.m. to 3 p.m., seven patients, or fraction thereof, to one from 3 p.m. to 11 p.m., and fifteen patients, or fraction thereof, to one from 11 p.m. to 7 a.m.

(f) **Diagnostic and therapeutic facilities.** Facilities, equipment and qualified personnel, under competent medical supervision, shall be provided for necessary diagnostic and therapeutic procedures, adequate for the needs of the hospital. These shall include, as a minimum, a clinical laboratory, pathology services, a radiology department and an operating room.

(g) **Pharmacy.** (1) There shall be a competent pharmacist, registered in Connecticut, who shall be responsible to the administrator for all pharmaceutical services in the hospital. In general and special hospitals of one hundred beds or more, he shall serve on a full-time basis. (2) The hospital pharmacy shall be operated in compliance with all applicable state and federal drug laws and regulations. (3) The premises shall be kept clean, adequately lighted, and ventilated, and the equipment and facilities necessary for compounding, dispensing, manufacturing, producing or processing of drugs shall be maintained in good order. (4) Drugs used in the hospital shall meet standards established by the United States Pharmacopeia, The National Formulary or the Federal Food and Drug Administration and shall be stored and kept so as to insure their proper purity and strength. A medical staff pharmacy committee in conference with the pharmacist shall formulate policies to control the administration of toxic or dangerous drugs with specific reference to the duration of the order and the dosage.

(h) **Dietary Service.** (1) Adequate space, equipment and qualified personnel shall be provided to ensure proper selection, storage, preparation and serving of regular and special diets to patients at regularly scheduled hours. (2) Menus shall be posted and shall meet state department of health requirements for basic nutritional needs. (3) Methods of dishwashing and sanitizing, food handling and garbage disposal shall comply with the requirements of the state department of health.

(i) **General.** (1) The hospital shall have an adequate laundry service. This may be provided within the hospital or purchased outside the hospital. (2) Adequate housekeeping and maintenance services shall be provided. (3) Proper heat, hot water, lighting and ventilation shall be maintained at all times. (4) There shall be a system of communication sufficient to meet the needs of the hospital. (5) Other departments, professional and service, shall be provided as necessary to the size and scope of the hospital. (6) The management, personnel, equipment, facilities, sanitation and maintenance of the hospital shall be such as reasonably to ensure the health, comfort and safety of the patients at all times. (7) Reports of suicides or accidents or injuries which may result in a permanent defect, scar or handicap shall be made to the state department of health within twenty-four hours.

(j) **Emergencies.** Provision shall be made to maintain essential services during disaster and similar emergency situations.

(Effective April 4, 1972; amended August 27, 2004)

Sec. 19-13-D4b.

Repealed, July 31, 2012.

EDITOR'S NOTE: Pages 18 through 36 of Section 19-13-D are left blank by the repeal of Section 19-13-D4b on July 31, 2012, and are intentionally omitted.

Sec. 19-13-D5. Long-term hospitals: Chronic disease hospital

(a) **Physical plant.** (1) The hospital buildings shall be of sound construction and shall provide adequate space and equipment for patient accommodations and for service and other areas, in accordance with the requirements of the state department of health. Properly equipped diagnostic and therapeutic facilities shall be provided. (2) The hospital buildings and equipment shall meet the requirements of the state fire safety code. (Reg. 29-40-1 et seq.) Annual application for a license shall be accompanied by a certificate of inspection by the local fire marshal. (3) Areas in which explosive gases are used, and areas in which radioactive materials are used, shall meet the requirements of the state department of health for adequate protection of patients and personnel. (4) The hospital buildings and equipment shall be maintained in a good state of repair and shall be kept clean at all times.

(b) **Administration.** (1) The hospital shall be managed by a governing board whose duties shall include, as a minimum: (A) Adoption of bylaws, rules and regulations, including medical staff bylaws; (B) annual appointment of the medical staff; (C) appointment of a competent hospital administrator; (D) establishment of

a joint conference committee composed of an equal number of representatives of the governing board and of the medical staff, and the administrator of the hospital. (2) The administrator shall be responsible to the governing board for the management and operation of the hospital and for the employment of personnel. He shall attend meetings of the governing board and meetings of the medical staff and shall be a member of the joint conference committee. (3) Personnel shall be employed in sufficient numbers and of adequate qualifications that the functions of the hospital may be performed efficiently.

(c) **Medical staff.** (1) There shall be an organized medical staff of not fewer than five physicians, one of whom shall serve as a chief or president of the medical staff. (2) The medical staff shall adopt written rules and regulations governing its own activities, subject to approval by the governing board of the hospital. As a minimum, these shall include: (A) Method of control of privileges granted to members of the medical staff; (B) method of control of clinical work; (C) provision for regular staff conferences; (D) regulations for preparation of medical records; (E) appointment of committees, to include medical record committee (or medical audit committee), representatives to joint conference committee and others as necessary; (F) procedure for recommending appointments to the medical staff and for hearing complaints regarding the conduct of members and referring the same, with recommendations, to the governing board. (3) Medical staff conferences shall be held once each month or more frequently. If all clinical groups hold departmental conferences at least monthly, general staff conferences may be less frequent, but there shall be a minimum of four each year. Conferences shall be planned to implement improved service to patients and shall be devoted primarily to thorough review and analysis of clinical work and discussion of interesting cases. All meetings shall be attended by at least seventy-five per cent of the active staff members. Minutes and a record of attendance shall be kept.

(d) **Medical records.** (1) There shall be a medical record department with adequate space, equipment and qualified personnel, to include at least one registered record librarian or a person with equivalent training and experience, in a hospital of one hundred beds or over. (2) A medical record shall be started for each patient at the time of admission with complete identification data and a nurse's notation of condition on admission. To this shall be added immediately an admission note and orders by the attending or a resident physician. A complete history and physical examination shall be recorded by the physician within twenty-four hours of admission and always before surgery, except in cases of unusual emergency. (3) All medical records shall include proper identification data; the clinical records shall be prepared accurately and completed promptly by physicians and shall include sufficient information to justify the diagnosis and warrant the treatment; doctors' orders, nurses' notes and charts shall be kept current in an acceptable manner; all entries shall be signed by the person responsible for them. (4) Medical records shall be filed in an accessible manner in the hospital and shall be kept for a minimum of twenty-five years after discharge of patients, except that original medical records may be destroyed sooner if they are microfilmed by a process approved by the state department of health. (5) Medical records shall be completed within fourteen days after discharge of the patient except in unusual circumstances which shall be specified in the medical staff rules and regulations. Persistent failure by a physician to maintain proper records of his patients, promptly prepared and completed, shall constitute grounds for suspending or withdrawing his medical staff privileges.

(e) **Nursing service.** (1) There shall be competent nurse as director of nursing service, registered in Connecticut, who shall be responsible to the administration

for nursing service in the hospital. (2) The ratio of patients to registered nurses on duty throughout the hospital shall at no time exceed thirty patients, or fraction thereof, to one registered nurse from 7 a.m. to 3 p.m.; thirty-five patients, or fraction thereof, to one registered nurse from 3 p.m. to 11 p.m.; and forty-five patients, or fraction thereof, to one registered nurse from 11 p.m. to 7 a.m. (3) The ratio of patients to all nursing staff, registered nurses, licensed practical nurses and other nursing attendants on duty in the hospital, shall not exceed ten patients, or fraction thereof, to one from 7 a.m. to 3 p.m.; twelve patients, or fraction thereof, to one from 3 p.m. to 11 p.m.; and fifteen patients, or fraction thereof, to one from 11 p.m. to 7 a.m.

(f) **Diagnostic and therapeutic facilities.** Facilities, equipment and qualified personnel, under competent medical supervision, shall be provided for necessary diagnostic and therapeutic procedures, adequate for the needs of the hospital. These shall include, as a minimum, a clinical laboratory and radiological services as approved by the state department of health. Provision for surgical and pathological services, if not available in the hospital, shall be made by affiliation with a hospital qualified to render such services.

(g) **Pharmacy:** (1) There shall be a competent pharmacist, registered in Connecticut, who shall be responsible to the administrator for all pharmaceutical services in the hospital. In chronic disease and rehabilitation hospitals with more than one hundred beds, he shall serve on a full-time basis.

(2) The hospital pharmacy shall be operated in compliance with all applicable state and federal drug laws and regulations.

(3) The premises shall be kept clean, adequately lighted, and ventilated and the equipment and facilities necessary for compounding, dispensing, manufacturing, producing or processing of drugs shall be maintained in good order.

(4) Drugs used in the hospital shall meet standards established by the United States Pharmacopeia, The National Formulary or the Federal Food and Drug Administration and shall be stored and kept so as to insure their proper purity and strength. A medical staff pharmacy committee in conference with the pharmacist shall formulate policies to control the administration of toxic or dangerous drugs with specific reference to the duration of the order and dosage.

(h) **Dietary service.** (1) Adequate space, equipment and qualified personnel shall be provided to ensure proper selection, storage, preparation and serving of regular and special diets to patients at regularly scheduled hours.

(2) Menus shall be prepared and posted and shall meet state department of health requirements for basic nutritional needs.

(3) Methods of dishwashing and sanitizing, food handling and garbage disposal shall comply with the requirements of the state department of health.

(i) **General.** (1) The hospital shall have an adequate laundry service. This may be provided within the hospital or purchased outside the hospital.

(2) Adequate housekeeping and maintenance services shall be provided.

(3) Proper heat, hot water, lighting and ventilation shall be maintained at all times.

(4) There shall be a system of communication sufficient to meet the needs of the hospital.

(5) Other departments, professional and service, shall be provided as necessary to the size and scope of the hospital.

(6) The management, personnel, equipment, facilities, sanitation and maintenance of the hospital shall be such as reasonably to ensure the health, comfort and safety of the patients at all times.

(7) When a patient ceases to breathe and has no detectable pulse or blood pressure, the body shall be moved promptly to an otherwise unoccupied room in the same institution pending pronouncement of death by a physician who has personally viewed the body as required in section 7-62 of the General Statutes. The facility shall make available a room which will provide for the dignified holding of the body of the deceased person where it will not be exposed to the view of patients or visitors. The room so designated may be used for other purposes when not required for this purpose.

(j) **Emergencies.** Provision shall be made to maintain essential services during emergency situations.

(k) **Special conditions.** (1) Adequate facilities, equipment and qualified personnel under competent medical supervision shall be provided for diagnostic and therapeutic procedures necessary for the care of patients with a wide range of chronic diseases.

(2) Provision shall be made for physical and occupational therapy and for supervised recreational activities.

(l) **Infection control.** (1) Purpose. Each long-term hospital, chronic disease hospital including state facilities shall develop an infection prevention, surveillance, and control program which shall have as its purpose the protection of patients and personnel from hospital-associated infections and community-associated infections in patients admitted to the hospital.

(2) Authority. The hospital's regulations governing the structure and function of this program shall be approved by, and become a part of the bylaws or rules and regulations of, the medical staff of the hospital. The authority for this program shall be delegated to a hospital infection control committee which shall report on its activities with recommendations on a regular basis to the medical executive committee for its consideration and action.

(3) Committee membership. The membership of this committee shall include physicians from each major clinical department, representatives from the nursing service, pharmacy, laboratory, hospital administration, inhalation and physical therapy departments; and as appropriate a representative of the departments of central supply, dietary, laundry, housekeeping and the local health director.

(4) Committee function. The infection control committee shall (a) adopt working definitions of hospital associated infections; (b) develop standards for surveillance of incidence of nosocomial infection and conditions predisposing to infection; (c) develop a mechanism for monitoring and reporting infections in patients and environmental conditions with infection potential; (d) develop a mechanism for evaluation of infection and environmental infection potential, including identification wherever possible of hospital-associated infections and periodic review of the clinical use of antibiotics in patient care; (e) develop control measures including isolation policy, aseptic techniques, and a personnel health program.

(5) Chairman. The chairman of the hospital infection control committee shall be a physician or health care professional qualified by education or experience and with a special interest in, infection control.

(6) Coordinator. There shall be an individual employed by the hospital qualified by education or experience in infection prevention, surveillance, and control who shall conduct these aspects of the program as directed by the hospital infection control committee. This individual shall be directly responsible to, and be a member of, the infection control committee. This individual shall make a monthly report to this committee. The time allotted to this position shall be in accordance with current national and professional standards.

(7) Meetings. The infection control committee shall meet at least monthly. As a minimum, it shall (a) review information obtained from day-to-day surveillance activities of the program; (b) review and revise existing standards; (c) report to the medical executive committee.

(8) Education. There shall be regular in-service education programs regarding infection prevention, surveillance, and control for all appropriate hospital personnel, documentation of these programs shall be available to the state department of health for review.

(9) Records. The minutes of the committee shall document the review and evaluation of these data and the development and revision of measures for control of infection. These records shall be available to the state department of health for review.

(Effective December 1, 1977)

Sec. 19-13-D6. Homes for the aged and rest homes

(a) **Definitions.** as used in this section.

(1) "Administration of medication" means the direct application of a medication by inhalation, ingestion or any other means to the body of a person;

(2) "Advanced practice registered nurse" means an individual licensed pursuant to subsection (b) of section 20-94a of the Connecticut General Statutes;

(3) "Authorized prescriber" means a physician, dentist, physician assistant or advanced practice registered nurse;

(4) "Certification" means written authorization issued by the Connecticut League For Nursing or other department approved certifying organization to a person to administer medications.

(5) "Certified unlicensed personnel" means any program staff person who has completed a training program and successfully completed a written examination and practicum administered by the Connecticut League For Nursing or other department approved certifying organization;

(6) "Commissioner" means the Commissioner of Public Health or the Commissioner's designated representative;

(7) "Continuing education" means attendance at classes, seminars, workshops, conferences or forums, or other documented activities that improve one's knowledge, skills and abilities;

(8) "Department" means the Department of Public Health or any duly authorized representative thereof;

(9) "Medication" means any medicinal preparation including controlled substances, as defined in section 21a-240 of the Connecticut General Statutes;

(10) "Medication error" means failure to administer medication to a person, or failure to administer medication within one (1) hour of the time designated by the prescribing practitioner, or failure to administer the specific medication prescribed for a person, or failure to administer the medication by the correct route, or failure to administer the medication according to generally accepted medical practices, or failure to administer the correct dosage of medication;

(11) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine in this or another state;

(12) "Physician assistant" means an individual licensed pursuant to section 20-12b of the Connecticut General Statutes;

(13) "Program staff" means those persons responsible for the direct care of the residents;

(14) “Registered nurse” means a person with a license to practice as a registered nurse in Connecticut in accordance with chapter 378 of the Connecticut General Statutes;

(15) “Registered pharmacist” means a person with a license to practice as a registered pharmacist in Connecticut in accordance with Section 20-590 of the Connecticut General Statutes;

(16) “Resident” means any person receiving care in the residential care home;

(17) “Residential Care Home” means an institution that is licensed pursuant to section 19a-490 (c) of the Connecticut General Statutes having facilities and all necessary personnel to furnish food, shelter and laundry for two or more persons unrelated to the proprietor and in addition, providing services of a personal nature which do not require the training or skills of a licensed nurse. Additional services of a personal nature may include assistance with bathing, help with dressing, preparation of special diets and supervision over medications which are self-administered, or the administration of medications pursuant to subsection 19-13-D6 (m)(2) of the Regulations of Connecticut State Agencies;

(18) “Significant medication error” means a medication error, which is potentially serious or has serious consequences for a resident, such as, but not limited to, the administration of medication by the wrong route; for which the resident has a known allergy; which was given in a lethal or toxic dosage; or which causes serious medical problems resulting from the error; and

(19) “Staff” means personnel including volunteers who provide a service at a residential care home.

(b) **Physical plant.** A. General. Newly constructed facilities shall contain all the elements described herein and shall be built in accordance with the construction requirements outlined. Should there be a change of ownership of the facility, these standards shall be applicable insofar as existing structures physically permit. New additions and renovations to existing facilities shall be built in accordance with these standards. A safe, sanitary, and comfortable environment is a basic requirement for residents in the facility. If day care programs are to be incorporated in this building, additional supportive facilities shall be provided to accommodate the program. At no time shall any program reduce the minimum services required for this licensed facility.

(1) Site. (a) The site shall be away from nuisances or foreseeable future nuisances detrimental to the proposed project’s program, such as industrial development, or other types of facilities that produce noise, air pollution or foreign odors.

(b) No facility of more than one-hundred and twenty (120) beds shall be constructed without public water and sanitary sewers.

(c) The building shall be of sound construction and provide an adequate maintenance program to ensure that the interior, the exterior and the grounds of the building are clean and orderly. All essential mechanical, plumbing, and electrical equipment for resident accommodations shall be in accordance with the requirements of the state department of health.

(d) All plans and specifications for new construction and/or alterations shall be submitted to and approved by the state department of health prior to the start of construction.

(e) Roads and walks shall be provided within the property lines to the main entrance and for service, including loading and unloading space for delivery trucks. Adequate off-street paved and lined parking stalls shall be provided at the ratio of one for each three residents.

(f) There shall be open outdoor area adjacent to the facility with a minimum of one-hundred (100) square feet per resident. This area shall consist of lawn and plantings and shall not be obstructed by other structures or paved parking areas, roads or sidewalks.

(2) Code. (a) Every building hereafter constructed or converted for use, in whole or in part, as a home for aged and rest home shall comply with the requirements of the Basic Building Code, an prepared by the Public Works Department, State of Connecticut; except as such matters are otherwise provided in the rules and regulations authorized for promulgation under the provisions of the Basic Building Code.

(b) In addition to the state of Connecticut Basic Building Code, all homes for aged and rest homes must comply with the State of Connecticut Fire Safety Code, the National Fire Protection Association - 101 Life Safety Code, the State of Connecticut Labor Laws, local fire safety codes, zoning ordinances, and in cases where private water supply and/or sewerage is required, written approval of the local health officer and environmental health services division of the state of Connecticut department of health must be obtained. Only the most current code or regulation and the most stringent shall be used.

(3) Minimum services required. (a) Lobby, with visitors' toilet rooms (to include facilities for each sex) and public telephone.

(b) Business or administration office.

(c) Resident rooms (see Sec. 19-13-D6 (b), B.)

(d) Resident baths (see Sec. 19-13-D6 (b), C.)

(e) Resident toilet rooms (see Sec. 19-13-D6 (b), D.)

(f) Resident lounge or sitting room (see Sec. 19-13-D6 (b), E.)

(g) Resident dining and recreation rooms (see Sec. 19-13-D6 (b), F.)

(h) Resident recreation area (see Sec. 19-13-D6 (b), G.)

(i) Dietary facilities (see Sec. 19-13-D6 (b), H.)

(j) Central storage room (see Sec. 19-13-D6 (b), I.)

(k) Laundry (see Sec. 19-13-D6 (b), J.)

(l) Employees' facilities (see Sec. 19-13-D6 (b), K.)

(m) Details of construction (see Sec. 19-13-D6 (b), L.)

(n) Mechanical system (see Sec. 19-13-D6 (b), M.)

(o) Electrical system (see Sec. 19-13-D6 (b), N.)

(p) Emergency electric service (see Sec. 19-13-D6 (b), O.)

(q) Provision for holding expired persons (adequately sized and ventilated space in unobjectionable location).

B. Resident rooms. Each resident room shall meet the following minimum requirements:

(1) Net minimum room clear floor area exclusive of closets, toilet rooms, lockers or wardrobes and vestibule shall be one-hundred and fifty (150) square feet in single rooms and one-hundred and twenty-five (125) square feet per bed in multi-bed rooms. Minimum dimensions of rooms shall not be less than eleven feet (11').

(2) No resident room shall be designed to permit more than two (2) beds.

(3) Windows. Sills shall not be higher than three feet (3') above the finished floor. Insulated window glass or approved storm windows shall be provided.

(4) The room furnishing for each resident room shall include a bed with a firm water-proof mattress, bedside stand, reading light, dresser or bureau with mirror and one (1) comfortable chair

(5) Each resident's wardrobe or closet shall have a minimum clear dimension of one foot-ten inches deep by one foot-eight inches wide (1'10" deep by 1'8" wide) with full length hanging space, clothes rod and shelf.

(6) All resident rooms shall open to a common corridor (sheltered path of egress) which leads directly to the outside.

(7) Doors shall be three feet (3') wide and swing into the room.

(8) Ceiling height shall not be less than eight feet (8') above the finished floor.

(9) A resident unit shall be twenty-five (25) beds or fraction thereof.

C. Resident baths. Resident baths shall have one (1) separate shower or one (1) separate bathtub for each eight (8) beds not individually served. There shall be at least one (1) separate bathtub and one (1) separate shower in each resident unit. Grab bars shall be provided at all bathing fixtures. Each bathtub or shower enclosure in a central bathing area shall provide space for the private use of the bathing fixture and for dressing. Showers in central bathing areas shall not be less than four (4) square feet without curbs. Soap dishes in showers and bathrooms shall be recessed.

D. Resident toilet rooms. (1) A toilet room with lavatory shall be directly accessible from each resident room and from each central bathing area without going through the general corridor. One (1) toilet room may serve two (2) resident rooms but not more than four (4) beds.

(2) Grab bars shall be provided at all waterclosets.

(3) Doors to toilet rooms shall have a minimum clear width of three feet (3').

E. Resident lounge or sitting room. Each resident wing and/or floor shall contain at least one (1) lounge area of two-hundred and twenty-five (225) square feet or nine (9) square feet per resident, whichever is greater.

F. Resident dining and recreation rooms. (1) The total area designed for combined residents' dining and recreation purposes shall not be less than thirty (30) square feet per resident bed. Additional space shall be provided for non-residents if they participate in day care programs.

(2) Areas appropriate for an activities program shall be provided which shall; (a) be readily accessible to wheelchair visitors.

(b) be of sufficient size to accommodate equipment and permit unobstructed movement of residents and personnel responsible for instructing and supervising residents.

(c) have storage space to store equipment and supplies convenient or adjacent to the area or areas.

(d) have toilet and handwashing facilities readily accessible.

G. Resident recreation area. (1) Recreation areas are required.

(2) Space for recreation, if separated from dining area, shall contain fifteen (15) square feet per resident. This space shall be provided in one area. Lobby area shall not be included in recreation space.

(3) Ten (10) square feet per resident shall be provided for outdoor porches or paved patio areas.

H. Dietary facilities. The food service shall include space and equipment for receiving, storage, preparation, assembling and serving food; cleaning or disposal of dishes and garbage and space for a food service office in a facility of fifty (50) beds or more. In addition, the following shall apply:

(1) Kitchens shall be centrally located, segregated from other areas and large enough to allow for adequate equipment to prepare and care for food properly.

(2) Floors shall be waterproof, greaseproof, smooth and resistant to heavy wear, with covered corners and wall junctions. There shall be floor drains located where the most cleaning is required as in the dishwashing machine room, near the cooking area, etc.

(3) All equipment and appliances shall be installed to permit thorough cleaning of the equipment, the floor and the walls around them.

(4) A commercial dishwashing machine shall be provided in any facility with twenty-five (25) or more beds. A commercial dishwashing machine shall be in a separate room or in an area separated from the main kitchen by a partition of five feet (5') minimum height. There shall be adequate openings for entrance and exit of carts. There shall be space for trucks with dirty dishes at the beginning of the counter. For facilities of less than twenty-five (25) beds, a dishwasher is still required.

(5) Outside ventilation openings shall be screened and provide at least ten (10) air changes per hour. A working ventilating fan is required. A strong exhaust fan in the hood over the range and steam equipment is required. The hood shall be a box type with straight sides and provided with a fire extinguishing system.

(6) Service pipes and lines in food cooking and preparation areas must be enclosed and insulated.

(7) A dining section within the kitchen area is prohibited.

(8) A hand washing sink with a soap dispenser shall be provided. Single service towels and a covered waste receptacle shall be provided in the kitchen area for the exclusive use of kitchen personnel.

(9) A janitor's closet shall be provided with a floor receptor or service sink, storage space for housekeeping equipment and supplies, and shall be located within the dietary department.

(10) Food service equipment shall be arranged for efficient, safe work flow, a separation of clean and contaminated functions and shall provide: (a) Potwashing facilities.

(b) Refrigerated storage for at least a three-day supply of food.

(c) Dry storage for at least a three-day supply of food.

(d) Enclosed waste disposal facilities.

(e) A toilet room with lavatory conveniently accessible for dietary staff.

I. Central storage room. (1) A central storage room of not less than ten (10) square feet per resident bed concentrated in one area shall be provided, including shelving.

(2) Storage should be located according to use and demand, but not in residents' rooms.

J. Laundry. (1) This service, if provided, shall be used exclusively for laundry and shall be remote from resident and food service areas, be self-contained, and shall not be accessible through any other room. The design shall provide for the separation of clean and soiled functions and shall include: (a) Basic mechanical services required for the installation of the laundry.

(b) A soiled linen room.

(c) A clean linen room separated from the soiled linen room.

(d) Linen cart storage space.

(e) A laundry processing room with equipment, including ironing, sufficient to process seven days' needs within the workweek.

(f) A janitor's closet with storage space for housekeeping supplies and equipment, and a floor receptor or service sink for the laundry area.

(g) Storage area for laundry supplies.

(2) If laundry is processed outside the facility, the facilities in subdivisions (e) (f) and (g) need not be provided although space shall be designed in the laundry area for future installation of these areas as needed.

(3) Each facility shall have a separate area easily accessible to the resident for a domestic type washer and dryer for residents' personal clothing and equipped for ironing. Coin-operated equipment shall not be provided.

(4) Facilities without city water or sanitary sewers shall not provide for commercial laundry processing on the well or leaching system serving the domestic needs of the facility.

K. Employees facilities. (1) Toilet rooms. A separate room for each sex shall be provided for employees' use only. One (1) watercloset and one (1) lavatory shall be for each twenty (20) employees of each sex up to one hundred (100) employees, and one (1) water-closet and (1) lavatory for each additional twenty-five (25) employees over one-hundred (100) employees. Provide one (1) urinal for nine (9) or more males up to forty (40) employees.

(2) Locker rooms. Separate locker rooms for each sex shall be provided, with adequate segregated space for employees' clothing and personal effects. These lockers shall be installed in a completely divided area from the waterclosets and lavatories.

(3) Dining room. A separate dining room shall be provided for employee use in the amount of fifteen (15) square feet per employee dining at one time. This dining room shall not be included in the space requirement for any other area nor shall serve any other purpose.

L. Details of construction. A high degree of safety for the occupants in minimizing the incidence of accidents shall be provided. Hazards such as sharp corners shall be avoided. All details and finishes shall meet the following requirements:

(1) Corridors shall be at least six feet (6') wide.

(2) No door shall swing into the corridor.

(3) Handrails shall be provided on both sides of all corridors used by residents. They shall have ends rounded and returned to the walls, a clear distance of one and one-half inches (1½") between handrail and wall and a height of thirty-two inches to thirty-four inches (32" to 34") above the finished floor.

(4) Thresholds and expansion joint covers shall be flush with the finished floor.

(5) Such items as drinking fountains, telephone booths, and vending machines shall be located so as not to project into the required width of exit corridors.

(6) All doors to resident toilet rooms, bathrooms and shower rooms shall be equipped with hardware which will permit access in any emergency.

(7) All doors opening to corridors shall be swing-type. Alcoves and similar spaces which generally do not require doors are excluded from this requirement.

(8) Grab bars and accessories in resident toilet rooms, shower rooms, and bathrooms shall have sufficient strength and anchorage to sustain a load of two-hundred and fifty (250) pounds for five (5) minutes.

(9) If linen and refuse chutes are used, they shall be designed as follows:

(a) Service openings to chutes shall have approved Class "B," one and one-half (1½) hour fire rated doors.

(b) Service openings to chutes shall be located in a room or closet of not less than two (2) hour fire-resistive construction, and the entrance door to such room or closet shall be a Class "B," one and one-half (1½) hour fire rated door.

(c) Minimum diameter of gravity-type chutes shall be two feet (2') with wash-down device.

(d) Chutes shall terminate in or discharge directly into collection rooms separate from laundry or other services. Separate collection rooms shall be provided for refuse and linen. Such rooms shall be of not less than two (2) hour fire-resistive construction and the entrance door shall be a Class "B," one and one-half (1½) hour fire rated door with hardware as required by NFPA.

(e) Chutes shall extend at least four feet (4') above the roof and shall be covered by an explosive type hatch.

(f) Chutes shall be protected internally by automatic sprinklers. This will require a sprinkler-head at the top of the chute and, in addition, a sprinkler-head shall be installed within the chute at alternate floor levels in buildings over two (2) stories in height. The room into which the chute discharges shall also be protected by automatic sprinklers.

(10) Dumbwaiters, conveyors, and material handling systems shall not open into any corridor or exitway but shall open into a room enclosed by not less than two (2) hour 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.

(11) Janitor's closet. This room shall contain a floor receptor or service sink and storage space for housekeeping supplies and equipment. One (1) janitor's closet may serve a fifty (50) bed unit on each floor.

(12) Ceiling heights: (a) Boiler room shall be not less than two feet - six inches (2' 6") above the main boiler header and connecting piping with adequate headroom under piping for maintenance and access.

(b) Storage rooms, residents' toilet rooms, and other minor rooms shall be not less than seven feet - eight inches (7' 8") above the finished floor.

(c) All other rooms and corridors shall be not less than eight feet (8') above the finished floor.

(13) Boiler rooms, food preparation centers, and laundries shall be insulated and ventilated to prevent any floor surface above from exceeding a temperature of ten degrees (10°) Fahrenheit above the ambient room temperature.

(14) Approved fire extinguishers shall be provided in recessed locations throughout the building not more than five feet (5') above the floor.

(15) For flame spread requirements, see the State of Connecticut Fire Safety Code.

(16) Floors generally shall be easily cleanable and shall have the wear resistance appropriate for the location involved. Floors in kitchens and related spaces shall be waterproof and greaseproof. In all areas where floors are subject to wetting, they shall have a non-slip finish.

(17) Adjacent dissimilar floor materials shall be flush with each other to provide an unbroken surface.

(18) Walls generally shall be washable and in the immediate area of plumbing fixtures, the finish shall be moistureproof. Wall bases in dietary areas shall be free of spaces that can harbor insects.

(19) Ceilings generally shall be washable or easily cleanable. This requirement does not apply to boiler rooms, mechanical and building equipment rooms, shops and similar spaces.

(20) Ceilings shall be acoustically treated in corridors and resident occupied areas.

(21) All resident occupied rooms shall be provided with at least one and three-quarter inch (1^{3/4}"), threequarter (3/4) hour wood or metal door equal to "C" label construction with metal frame and positive latching.

(22) All operable windows shall be provided with screens.

M. Mechanical system. (1) Elevators. (a) At least one elevator shall be installed where one to fifty (1 to 50) resident beds are located on any floor other than the main entrance floor, or where resident facilities are located on a floor other than those containing resident beds.

(b) At least two (2) elevators shall be installed where fifty-one to one-hundred and fifty (51 to 150) resident beds are located on floors other than the main entrance

floor, or where resident facilities are located on a floor other than those containing resident beds.

(c) At least three (3) elevators shall be installed where one-hundred and fifty to three-hundred and fifty (150 to 350) resident beds are located on floors other than the main entrance floor or where resident facilities are located on a floor other than those containing resident beds.

(d) For facilities with more than three-hundred and fifty (350) beds, the number of elevators shall be determined from a study of the facility plan and the estimated vertical transportation requirements.

(e) An elevator vestibule shall be provided on each floor meeting the requirements of two (2) hour fire-resistant construction with self-closing one and one-half (1^{1/2}) hour fire rated doors held open by electro-magnetic hold open devices connected to an automatic alarm system.

(2) Steam and hot water systems. (a) Boilers shall have the capacity, based upon the published Steel Boiler Institute or Institute of Boiler and Radiator Manufacturers' net ratings, to supply the normal requirements of all systems and equipment. If the licensed capacity of the facility exceeds one-hundred (100) beds, a second boiler shall be required.

(b) Boiler feed pumps, condensate return pumps, fuel oil pumps, and circulating pumps shall be connected and installed to provide standby service when any pump breaks down.

(c) Supply and return mains and risers of space heating and process steam systems shall be valved to isolate the various sections of each system. Each piece of equipment shall be valved at the supply and return end.

(d) Boilers' and smoke breeching stacks, all steam supply piping and high pressure steam return piping and hot water space heating supply and return piping shall be insulated.

(3) Air conditioning, heating and ventilating systems: (a) A minimum temperature of seventy-five degrees Fahrenheit (75° F.) shall be provided for all occupied areas at winter design conditions.

(b) All air-supply and air-exhaust systems shall be mechanically operated. All fans serving exhaust systems shall be located at or near the point of discharge from the building.

(1) Outdoor ventilation air intakes, other than for individual room units, shall be located as far away as practicable but not less than twenty-five feet (25') from exhausts from any ventilating system or combustion equipment. The bottom of outdoor intakes serving central air systems shall be located as high as possible but not less than eight feet (8') above the ground level or, if installed through the roof, three feet (3') above roof level.

(2) The ventilation systems shall be designed and balanced to conform to accepted standards and/or applicable codes.

(3) Room supply air inlets, recirculation, and exhaust air outlets shall be located not less than three (3") inches above the floors.

(4) Corridors shall not be used to supply air to or exhaust air from any room. All interior rooms shall be mechanically ventilated.

(5) An approved fire damper shall be provided on each opening through each fire or smoke wall partition and on each opening through the floor of a vertical shaft.

(6) Cold air ducts shall be insulated where necessary to maintain the efficiency of the system or to minimize condensation problems.

(7) Exhaust hoods in food preparation centers shall have a minimum exhaust rate of one-hundred (100) cubic feet per minute per square foot of hood face area. All hoods over cooking ranges shall be equipped with fire extinguishing systems and heat-activated fan controls. Cleanout openings shall be provided every twenty feet (20') in horizontal exhaust duct systems serving hoods.

(8) Boiler rooms shall be provided with sufficient out-door air to maintain combustion rates of equipment and reasonable temperatures in the room and in adjoining areas.

(4) Plumbing and other piping systems. (a) Plumbing fixtures. (1) The material used for plumbing fixtures shall be of non-absorptive acid-resistant material.

(b) Water supply systems. (1) Systems shall be designed to supply water to the fixtures and equipment on the upper floors at a minimum pressure of fifteen (15) pounds per square inch during maximum demand periods.

(2) 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.

(3) Hot, cold and chilled water piping and waste piping on which condensation or unnecessary heat loss may occur shall be insulated.

(4) Backflow preventers (vacuum breakers) shall be installed on hose bibbs and on all fixtures to which hoses or tubing can be attached such as janitors' sinks.

(5) Flush valves installed on plumbing fixtures shall be of a quiet operating type.

(6) Hot water distribution systems shall be arranged to provide hot water at each hot water outlet at all times.

(7) Plumbing fixtures which require hot water and which are intended for resident use shall be supplied with water which is controlled to provide a water temperature ranging between one-hundred and ten degrees to one-hundred and twenty degrees Fahrenheit (110° to 120° F.) at the fixture.

(c) Hot water heaters and tanks. The hot water heating equipment shall have sufficient capacity to supply the water at the temperatures and amounts as required.

(d) Drainage systems. Piping over food preparation centers, food serving facilities, food storage areas, and other critical areas shall be kept to a minimum and shall not be exposed. Special precautions shall be taken to protect these areas from possible leakage of or condensation from necessary overhead piping systems.

(c) Fire extinguishing systems. Automatic fire extinguishing systems shall be installed in areas such as: Central soiled linen holding rooms, maintenance shops, refuse collection rooms, bulk storage rooms, and adjacent corridors, attics accessible for storage, and refuse chutes. Storage rooms of less than one-hundred (100) square feet in area and spaces used for storage of non-hazardous materials are excluded from this requirement if construction is non-combustible.

N. Electrical system. (1) Circuit breakers or fusible switches that provide disconnecting means and overcurrent protection for conductors connected to switchboards and distribution panelboards shall be enclosed or guarded to provide a dead-front type of assembly. The main switchboard shall be located in a separate enclosure accessible only to authorized persons. The switchboard shall be convenient for use, readily accessible for maintenance, clear of traffic lanes, and in a dry ventilated space free of corrosive fumes or gases. Overload protective devices shall be suitable for operating properly in the ambient temperature conditions.

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

(3) All spaces occupied by people, machinery, and equipment within the building, and the approaches thereto, and parking lots shall have electric lighting.

- (a) Residents' bedrooms shall have general lighting.
- (b) One lighting fixture for general lighting shall be exclusively wired to a switch at the entrance to each resident room.
- (c) A reading light shall be provided for each resident.
- (d) Residents' reading lights shall not be switched at the door.
- (e) All switches for control of lighting in resident areas shall be of the quiet operating type.

(4) Each resident bedroom shall have duplex receptacles at least eighteen inches (18") above the floor as follows: One on each side of the head of each bed, for parallel beds. Only one duplex receptacle is required between beds, and one on at least one other wall. Single receptacles for equipment, such as floor cleaning machines, shall be installed approximately fifty feet (50') apart in all corridors. Duplex receptacles for general use shall be installed approximately fifty feet (50') apart in all corridors and within twenty-five feet (25') of ends of corridors.

(5) A calling station shall be installed in each resident room to meet the following requirements: Each resident room shall be equipped with at least an audible call bell system connected to an annunciator panel in the manager's office and employees' sleeping area where there is staff twenty-four (24) hours a day. If the office is not staffed twenty-four (24) hours a day, the call system shall indicate the source of the call, both audibly and visually. In addition to activating the annunciator panel, the call bell shall turn on a light located directly over the door of the resident room. In lieu of this requirement, a telephone system may be used if the same functions are accomplished when the receiver is lifted.

(6) A manually-operated, electrically-supervised fire alarm system shall be installed in each facility. In multistory buildings, the signal shall be coded or otherwise arranged to indicate the location of the station operated. The fire alarm system should be connected to a municipal system, if possible. Pre-signal systems will not be permitted. In multi-story buildings, with more than twenty-five (25) residents, an annunciator panel shall be provided.

O. Emergency electric service. (1) To provide electricity during an interruption of the normal electric supply that could affect the care and safety of the occupants, an emergency source of electricity shall be provided and connected to all circuits for lighting and power.

(2) The source of this emergency electric service shall be as follows: (a) All emergency generating set, including the prime mover and generator, equipped with an automatic transfer switch, shall be located on the premises and shall be reserved exclusively for supplying the emergency electrical system. The emergency generator set shall be of sufficient kilowatt capacity to supply all lighting and power load demands of the emergency system and shall have an automatic transfer switch which will start the emergency generator within ten (10) seconds. The power factor rating of the generator shall be not less than eighty percent (80%). Where fuel is normally stored on the site, the storage capacity shall be sufficient for three (3) days operation of required emergency electric services. Where fuel is normally piped underground to the site from a utility distribution system, storage facilities on the site will not be required.

(3) Emergency electric service shall be provided to circuits as follows: (a) Where electricity is the only source of power normally used for space heating, the emergency service shall provide for heating of all resident bedrooms and resident service areas such as dining rooms, day rooms and recreation areas. Emergency heating of resident bedrooms will not be required in areas where the home is supplied by at least two

(2) utility service feeders, or a network distribution system fed by two (2) or more generating sources, with the feeders so routed, transfer switch connected, and protected that a fault any place between the sources and the facility will not likely cause an interruption of more than one of the service feeders.

(b) Where more than one (1) elevator is provided, at least one (1) shall be connected to the emergency electrical system.

P. If residents are housed in two (2) or more buildings not directly connected one with another, each such building shall be treated as a separate unit.

Q. Each resident room shall be numbered; the number, together with the licensed capacity of each room, shall be posted by each door. The census shall not exceed the number for which the license is issued, nor shall the number of residents in any room exceed the licensed capacity of that room.

R. The buildings, equipment and precautions taken to provide for the safety of residents and employees shall be approved by the state department of health. An annual certificate from the local fire marshal that fire precautionary measures meet his approval shall be submitted with the annual application for license.

S. The buildings, equipment and site shall be maintained in a good state of repair and shall be kept clean at all times.

(c) **Administration.**

(1) The proprietor or licensee of the residential care home shall be responsible for operation of the residential care home in compliance with these regulations.

(2) The proprietor or licensee of the residential care home shall be responsible for submitting every two years to the department an application for license and such reports as may be required.

(3) The licensee shall furnish, with his initial application, character references from three responsible people not related to him. He shall also furnish, every two years with his initial and each subsequent application, a certificate of physical and mental health signed by a physician.

(4) Sufficient capable personnel of good character and suitable temperament shall be employed to provide satisfactory care for the residents.

(A) The residential care home shall maintain records on file at the residential care home documenting that all new staff received an initial orientation prior to being allowed to work independently including, but not limited to, safety and emergency procedures for staff and residents, the policies and procedures of the residential care home, and resident rights. Such records shall be kept at the residential care home for not less than two (2) years after the termination of employment of the staff person or service as a volunteer.

(B) Continuing education for program staff shall be required for one (1) percent of the total annual hours worked (to a maximum of twelve (12) hours) per year. Such education shall include, but is not limited to, resident rights, behavioral management, personal care, nutrition and food safety, and health and safety in general.

(C) The licensee of the residential care home shall develop, implement and maintain a written plan for continuing education for program staff at the residential care home.

(D) The licensee shall have records of continuing education for each program staff member at the residential care home which is available to the department for review upon request. Such records shall be kept for not less than two (2) years after the termination of employment of an employee.

(5) The management, personnel, equipment, facilities, sanitation and maintenance of the home shall be such as reasonably to ensure the health, comfort and safety of the residents at all times.

(d) **Medical supervision.** In case of illness of a resident the licensee of the home or the person in charge is responsible for obtaining the services of a physician.

(e) **Records.** A record of each resident, to include the name, residence, age, sex, nearest relative, religion and other necessary information, shall be kept on forms approved by the state department of health.

(f) **Dietary service.** (1) Adequate space, equipment and qualified personnel shall be provided to ensure proper selection, storage, preparation and serving of regular and special diets to residents at regularly scheduled hours.

(2) Menus shall be prepared, posted and filed and shall meet state department of health requirements for basic nutritional needs.

(3) The time scheduling of regular meals and snacks shall be approved by the state department of health.

(4) Methods of dishwashing and dish sanitizing, food handling and garbage disposal shall comply with section 19-13-B42.

(g) **Recreation.** Recreational activities shall be provided in homes for the aged. Space and equipment provided for recreational activities shall be approved by the state department of health.

(h) **General conditions.** (1) Residents shall be admitted only on referral from a responsible source. No residents may be admitted on an emergency basis except in the event of a major disaster, in which case the state department of health shall be notified at the earliest possible time.

(2) Provisions for visiting hours shall be as liberal as may be consistent with good resident care. Personnel shall treat both residents and their visitors with courtesy and consideration at all times.

(3) Any accident, disaster or other unusual occurrence in the institution shall be reported within seventy-two hours to the state department of health.

(4) Proper heat, hot water, lighting and ventilation shall be maintained at all times.

(5) There shall be a system of communication sufficient to meet the needs of the institution and the requirements of the state department of health.

(6) Adequate housekeeping, laundry and maintenance services shall be provided.

(7) Licenses are not transferable and are in effect only for the operation of the institution as it is organized at the time the license is issued. The state department of health shall be immediately notified if the licensee plans any structural changes, plans to sell the institution or plans to discontinue operation.

(8) When an institution changes ownership, the new licensee shall not only comply with all the requirements of these regulations but shall, in addition, comply with the requirements for new structures.

(9) Institutions caring for more than four persons shall comply with the state fire safety code. (Reg. 29-40-1 et seq.)

(10) The site of new institutions shall be approved by the state department of health.

(11) Private water supplies and/or sewerage if installed shall be in accordance with the state public health code (Reg. 19-13-A1 et seq.) and with written approval by the local director of health.

(12) All plans and specifications for new construction or alterations shall be submitted to the state department of health, the local fire marshal, the local building inspector, if any, and the local zoning authorities for approval before construction is undertaken.

(13) No person shall be admitted to or housed in the institution if such person is not under the direct supervision of the licensee.

(14) When a patient ceases to breathe and has no detectable pulse or blood pressure, the body shall be moved promptly to an otherwise unoccupied room in the same institution pending pronouncement of death by a physician who has personally viewed the body as required in section 7-62 of the General Statutes. The facility shall make available a room which will provide for the dignified holding of the body of the deceased person where it will not be exposed to the view of patients or visitors. The room so designated may be used for other purposes when not required for this purpose.

(i) **Special Conditions.**

(1) Egress passages from each resident floor of the institution shall be such that all occupants of the floor can safely travel to a place of safety outside the building.

(2) In combustible buildings the third floor above the basement shall not be converted to resident use after January 1, 1960, unless a passenger elevator is installed to serve each floor.

(j) **Attendants required.** At no time shall there be less than one attendant on duty for each twenty-five residents or fraction thereof from 7 a.m. to 10 p.m. and one attendant in residence for each twenty-five residents from 10 p.m. to 7 a.m.

(k) **Classification of civil penalty violations for Homes for the Aged and Rest Homes.** Any home for the aged and rest home 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 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 any of the following provisions shall result in a Class A violation:

- (A) 19-13-D6 (b) N (6);
- (B) 19-13-D6 (b) R;
- (C) 19-13-D6 (f) (4);

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

- (A) 19-13-D6 (b) A (2) (b);
- (B) 19-13-D6 (b) M (4) (b) (7);
- (C) 19-13-D6 (b) O (1); (2);
- (D) 19-13-D6 (c) (1); (4);
- (E) 19-13-D6 (d) ;
- (F) 19-13-D6 (f) (1);
- (G) 19-13-D6 (h) (4);
- (H) 19-13-D6 (i) (1); (2);
- (I) 19-13-D6 (j).

(l) **Exemption**—No civil penalty shall be imposed for an existing structural condition not in conformance with the Public Health Code, which is authorized to continue to exist in accordance with provisions of Section 19-13-D6(b)A of the Regulations of Connecticut State Agencies.

(m) **Administration of Medications.**

Residents of licensed residential care homes may self administer medications, and may request assistance from staff with opening containers or packages and replacing lids. If the residential care home permits the administration of medications of any kind by unlicensed personnel, unlicensed personnel who administer medications in the residential care home must be certified and comply with all requirements

of subsection (m) of this section and have written policies and procedures at the residential care home governing the administration of medications which shall include, but not be limited to, the types of medication that will be administered, resident responsibilities, staff responsibilities, proper storage of medication and record keeping. Said policies and procedures shall be available for review by the department during inspections or upon demand and shall reflect best practice. Except as provided in subsection (m) of this section, unlicensed personnel who have not been certified shall not administer medication. Only program staff persons who are eighteen (18) years of age shall administer any medication at the residential care home.

(1) Administration of Non Prescription Topical Medications Only

(A) Description

For the purposes of subsection (m) of this section, non-prescription topical medications are:

- (i) ointments free of antibiotic, antifungal, or steroidal components;
- (ii) medicated powders; and
- (iii) gum or lip medications available without a prescription.

(B) Non Prescription Topical Medications Administration/Resident Permission Records

The written permission of the resident (or resident's conservator, guardian, or legal representative) shall be required prior to the administration of the non prescription topical medication(s) and a medication administration record shall be written in ink and kept on file at the residential care home for each resident administered a non prescription topical medication(s). The medication administration record and resident's permission shall become part of the resident's record when the course of medication has ended. Any medication administration error shall be documented in the record. This information shall include:

- (i) the name of the resident;
- (ii) the name of the medication;
- (iii) the schedule and site of administration of the medication, as applicable, according to the manufacturer's directions;
- (iv) the signature of the resident, or the name, address, telephone number, signature and relationship to the resident of the resident's conservator, guardian, or legal representative, authorizing the administration of the medication(s); and
- (v) the name of the person who administered the non-prescription topical medication.

(C) Non Prescription Topical Medications/Labeling and Storage

(i) The medication shall be stored in the original container and shall contain the following information on the container or packaging indicating:

- (I) the individual resident's name;
- (II) the name of the medication; and
- (III) directions for the medication's administration.

(ii) The medication shall be stored away from food and inaccessible to unauthorized persons.

(iii) Any expired medication shall be destroyed by the resident (or resident's conservator, guardian, or legal representative) or the program staff member in a safe manner.

(2) Administration of Medications Other Than Non Prescription Topical Medications

(A) Description

For the purposes of subsection (m) of this section, medications other than non-prescription topical medications are medications which are not described in subsection 19-13-D6 (m)(1)(A) and are:

- (i) oral medications
- (ii) topical medications, including eye and ear preparations;
- (iii) inhalant medications
- (iv) injectable medications, by a pre-measured, commercially prepared syringe, to a resident with a diagnosed medical condition who may require emergency treatment.

(B) Training Requirements

(i) Prior to the administration of any medication by program staff members, the program staff members who are responsible for administering the medications shall first be trained by a registered pharmacist, physician, physician assistant, advanced practice registered nurse or registered nurse in the methods of administration of medications and shall have received written verification from the trainer which indicates that the trainee has completed a training program as required herein and shall have successfully complete a written examination and practicum administered by the Connecticut League For Nursing or other department approved certifying organization. If the residential care home permits the administration of medication by certified program staff, a program staff member trained and certified to administer medication by the route ordered by the authorized prescriber shall be present at all times whenever a resident has orders to receive medication.

(ii) The training in the administration of medications shall be documented and shall include, but not be limited to the following:

(I) objectives;

(II) a description of methods of administration including principles and techniques, application and installation of oral, topical, and inhalant medication, including the use of nebulization machines;

(III) techniques to encourage residents who are reluctant or noncompliant to take their medication and the importance of communicating this information to the prescriber;

(IV) demonstration of techniques by the trainer and return demonstration by participants, assuring that the trainee can accurately understand and interpret orders and carry them out correctly, including medications that are ordered PRN (as needed);

(V) recognition of side effects and appropriate follow up action;

(VI) avoidance of medication errors and the action to take if an error occurs, or if a dosage is missed or refused;

(VII) abbreviations commonly used;

(VIII) documentation including resident (or resident's conservator, guardian, or legal representative) permission, written orders from the authorized prescriber, and the record of administration;

(IX) safe handling, including receiving medication from a resident (or resident's conservator, guardian, or legal representative), safe disposal, and universal precautions; and

(X) proper storage including the storage of controlled substances in accordance with Section 21a-262-10 of the Regulations of Connecticut State Agencies.

(iii) Injectable Medications

In addition to the above training, before a program staff member may administer injectable medications, he shall have completed a training program on the administration of injectable medications by a premeasured, commercially prepared syringe. The trainer who shall be a registered pharmacist, physician, physician assistant,

advanced practice registered nurse or registered nurse, shall assure that the program staff member understands the indications, side effects, handling and methods of administration for injectable medication. Thereafter, on a yearly basis, program staff members shall have their skills and competency in the administration of injectable medication recertified by the Connecticut League For Nursing or other department approved certifying organization. Injectable medications shall only be given in emergency situations, by a premeasured commercially prepared syringe, unless a petition for special medication authorization is granted by the department.

(iv) The trainer shall provide the trainee with an outline of the curriculum content, which verifies that all mandated requirements have been included in the training program. A copy of said outline shall be on file at the residential care home where the trainee is employed for department review. The department may require at any time that the licensee obtain the full curriculum from the trainer for review by the department.

(v) A program staff member currently certified by the State of Connecticut Department of Mental Retardation or other state agency to administer non-injectable medications shall be considered qualified to administer such medications at residential care homes.

(C) Certification

(i) In order to administer medication, unlicensed program staff shall be certified as applicable, in the administration of:

(I) oral, topical, and inhalant medications, or;

(II) oral, topical, inhalant, and pre-measured commercially prepared injectable medications.

(ii) Upon completion of training in the administration of medication and prior to the administration of any medication, program staff must successfully complete a written examination and practicum administered by the Connecticut League for Nursing or other Department approved certifying organization.

(iii) The written examination and practicum for oral, topical, and inhalant medications, shall include, but not be limited to the following:

(I) the elements in subsection 19-13-D6(m)(2)(B)(ii)(I) through 19-13-D6(m)(2)(B)(ii)(III), inclusive, and subsection 19-13-D6(m)(2)(B)(ii)(V) through 19-13-D6(m)(2)(B)(ii)(X), inclusive; The examination shall be graded PASS or FAIL. A numerical grade of at least 70% shall be considered passing; and

(II) the practicum shall consist of a return demonstration by the program staff person in which the program staff person shall complete three medication pour and passes which represent each route of administration; and shall demonstrate to a representative of the Connecticut League For Nursing or other Department approved certifying organization, that he can accurately understand and interpret orders of the authorized prescriber and carry them out correctly, including medications that are ordered PRN (as needed.) To pass the practicum for oral, topical, and inhalant medications, the program staff person must successfully complete each medication pour and pass with 100% accuracy.

(iv) The written examination and practicum for oral, topical, inhalant, and pre-measured commercially prepared injectable medications, shall include, but not be limited to the following:

(I) the elements in subsection 19-13-D6(m)(2)(B)(ii)(I) through 19-13-D6(m)(2)(B)(ii)(III), inclusive, and subsection 19-13-D6(m)(2)(B)(ii)(V) through 19-13-D6(m)(2)(B)(ii)(X), inclusive, and subsection 19-13-D6(m) (2)(B)(iii).; The

examination shall be graded PASS or FAIL. A numerical grade of at least 70% shall be considered passing; and

(II) the practicum shall consist of a return demonstration by the program staff person in which the program staff person shall complete three medication pour and passes which represent each route of administration and one demonstration using a premeasured commercially prepared injectable medication; and shall demonstrate to a representative of the Connecticut League For Nursing or other department approved certifying organization, that he can accurately understand and interpret orders of the authorized prescriber and carry them out correctly, including pre-measured commercially prepared injectable medications and medications that are ordered PRN (as needed.) To pass the practicum for oral, topical, inhalant, and pre-measured commercially prepared injectable medications, the program staff person must successfully complete each medication pour and pass with 100% accuracy; and one demonstration using a premeasured commercially prepared injectable medication with 100% accuracy.

(v) Upon completion of the written test and practicum, the Connecticut League For Nursing or other department approved certifying organization shall certify each program staff member who has demonstrated successful completion of the required written test and practicum for the administration of oral, topical, inhalant medications or for the administration of oral, topical, inhalant, pre-measured commercially prepared injectable medications Certification for the administration of oral, topical, inhalant medications shall be valid for three (3) years. Certification for the administration of injectable medications shall be valid for one (1) year. Certification shall be in writing. A copy of the certification shall be on file at the residential care home where the program staff member is employed and shall be available to department staff upon request.

(vi) Each individual who completes the required training program specified in subsection 19-13-D6 (m)(2) (B)(ii), and where certification is sought in injectable medications, subsection 19-13-D6 (m)(2)(B)(iii); and successfully completes a written examination and practicum as specified in subsection 19-13-D6 (m)(2)(C)(iii) or subsection 19-13-D6 (m)(2)(C)(iv), shall be given written certification authorizing him to administer medications to residents, as permitted in subsection (m) of this section. Written certification shall include:

(I) the full name, signature, title, license number, address and telephone number of the registered pharmacist, physician, physician assistant, advanced practice registered nurse or registered nurse who gave the written test and practicum;

(II) the location where and date(s) the test and practicum were given;

(III) a statement that the required curriculum areas listed in Section 19-13-D6 (m)(2)(B)(ii) and Sec.19-13-D6(m)(2)(B)(iii) when applicable were successfully mastered, and indicating the route(s) of administration the program staff has been approved to administer;

(IV) the name, date of birth, address, and telephone number of the program staff member who successfully completed the test and practicum; and

(V) the expiration date of the approval.

(D) Order From An Authorized Prescriber and Resident's Permission

(i) No medication, prescription or non prescription, shall be administered to a resident without the written order of an authorized prescriber and the written permission of the resident (or resident's conservator, guardian, or legal representative). Permission shall be maintained on file at the residential care home.

(ii) The written order from an authorized prescriber shall contain the following information which may be on the prescription label or on supplemental reference information approved or provided by the prescriber or pharmacist;

- (I) the name of the resident;
- (II) the date the medication order was written;
- (III) the medication or drug name, dose and method of administration;
- (IV) the time the medication is to be administered;
- (V) the date(s) the medication is to be started and ended as applicable;
- (VI) relevant side effects;
- (VII) notation if the medication is a controlled drug;
- (VIII) a listing of any allergies, reactions to, or negative interactions with foods or drugs;
- (IX) specific instructions from the authorized prescriber who orders the medication regarding how the medication is to be given; and
- (X) the name, address and telephone number of the authorized prescriber ordering the drug.

(iii) If the authorized prescriber determines that the training of the program staff member is inadequate to safely administer medication to a particular resident, that authorized prescriber may order that such administration be performed by licensed medical personnel with the statutory authority to administer medications.

(iv) The program staff member shall administer medication only in accordance with the written order of the authorized prescriber. The resident (or resident's conservator, guardian, or legal representative) shall be notified of any medication administration errors immediately. The error and the notification of the error shall be documented in the record.

(E) Required Records

(ii) Individual written medication administration records for each resident shall be written in ink, reviewed prior to administering each dose of medication and maintained on file at the residential care home. The medication administration record shall become part of the resident's health record when the course of medication has ended.

- (ii) The individual written administration record for each resident shall include:
- (I) the name of the resident;
 - (II) the name of the medication or drug;
 - (III) the dosage ordered and method of administration;
 - (IV) the date, time, and dosage at each administration;
 - (V) the signature or initials in ink, or a secured computerized document indicating the program staff member giving the medication; and
 - (VI) any refusal by the resident in accepting the medication.

(iii) Medication administration errors shall be recorded in the individual written administration record of the resident. Significant medication errors shall be reported in writing within seventy-two hours to the department.

(F) Storage and Labeling

(i) Medication shall be stored in the original container. The container or packaging shall have a label, which includes the following information:

- (I) the resident's name;
- (II) the name of the medication;
- (III) directions for the medication's administration; and
- (IV) the date of the prescription.

(ii) Medications shall be stored in a locked area or a locked container, in a refrigerator in keeping with the label or manufacturer's directions, away from food and inaccessible to unauthorized personnel. External medications shall be stored separately from internal medications. Keys to the locked area or container shall be accessible only to personnel authorized to administer medication. Controlled drugs shall be stored in accordance with Section 21a-262-10 of the Regulations of Connecticut State Agencies.

(iii) All expired medication, except for controlled drugs, shall be destroyed within one (1) week following the expiration date by flushing into sewerage or a septic system. The residential care home shall contact the Connecticut Department of Consumer Protection for direction

(iv) on the proper method of disposing of a controlled drug, and shall carry out the direction as required. The residential care home shall keep a written record of any medications destroyed.

(G) Petition for Special Medication Authorization

(i) The licensee of a residential care home may petition the department to administer medications to a resident by a modality which is not specifically permitted under these regulations by submitting a written application to the department, including the following information:

(I) a written order from an authorized prescriber containing the information for the specific resident set forth in subsection 19-13-D (6)(m)(2)(D) and a statement that the administration by the requested modality is the only reasonable means of providing medication;

(II) a written training plan including the full name, signature, title, license number, address and telephone number of the registered pharmacist, physician, physician assistant, advanced practice registered nurse or registered nurse who will provide the training, a detailed outline of the curriculum areas to be covered in training, and a written statement by the authorized prescriber that the proposed training is adequate to assure that the medication will be administered safely and appropriately to the particular resident;

(III) the name, date of birth, address and telephone number of the person(s) who shall participate in the training;

(IV) written permission from the resident (or resident's conservator, guardian, or legal representative); and

(V) such other information that the department deems necessary to evaluate the petition request.

(ii) After reviewing the submitted information, if the department determines that the proposed administration of medication for the particular resident can be provided in a manner to assure the health, safety and welfare of the resident, it may grant the petition. The department may grant the petition with any conditions or corrective measures, which the department deems necessary to assure the health, safety and welfare of the resident. The department will specify the curriculum that the training program shall cover and the expiration date of the authorization provided in granting the petition. If the department grants the petition, no medication may be administered until after the proposed training program has been successfully completed and a written approval from the registered pharmacist, physician, physician assistant, advanced practice registered nurse or registered nurse who provided the training is submitted to the department. The approval shall include:

(I) the full name, signature, title, license number, address and telephone number of the registered pharmacist, physician, physician assistant, advanced practice registered nurse or registered nurse who provided the training;

(II) the location and date(s) the training was given;

(III) a statement that the curriculum approved by the department was successfully mastered and stating the modality of administration of medication that the trainee has been approved to administer; and

(IV) the name, date of birth, address and telephone number of the person(s) who successfully completed the training.

(iii) Copies of all documentation required under this subsection shall be maintained at the residential care home. The requirements of subsection 19-13-D6 (m)(2)(E) and 19-13-D6 (m)(2)(F) shall apply to the administration of medication authorized by petition.

(3) Department Action

The Licensee shall comply with the policies and procedures adopted pursuant to subsection (m) of this section. Any failure to comply with such policies or procedures or any other provisions of this section shall constitute a Class B violation under Section 19a-527 of the Connecticut General Statutes.

(Effective March 1, 1988; amended December 4, 1998, April 2, 2002)

Secs. 19-13-D7—19-13-D7q.

Repealed, October 1, 1981.

Sec. 19-13-D7r.

Repealed, August 20, 1982.

Sec. 19-13-D7s.

Repealed, March 27, 1990.

Secs. 19-13-D8—19-13-D8q.

Repealed, October 1, 1981.

Sec. 19-13-D8r.

Repealed, August 20, 1982.

Sec. 19-13-D8s.

Repealed, March 27, 1990.

Sec. 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 Public Health;

(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 Public Health;

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

(8) “Feeding assistant” means an individual who has successfully completed a state approved training program and who is paid or under contract with a facility

to orally feed patients who do not have complicated feeding problems as provided in section 19-13-D8t (1)(9)(D) of the Regulations of Connecticut State Agencies, but does not include an individual who is a licensed practical nurse, registered nurse or other health professional otherwise licensed or certified by the department, or volunteers who provide such services without monetary compensation or a family member assisting a relative;

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

(10) “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;

(11) “Licensed nursing personnel” means registered nurses or licensed practical nurses licensed in Connecticut;

(12) “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;

(13) “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;

(14) “Personal physician” means the physician indicated on the patient’s medical record as being responsible for the medical care of that patient;

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

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

(17) “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.

(i) 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:

(i) 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 for 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 non-physician 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.

(4) 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 and Feeding Assistant 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 shall 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 shall be in a chronic and convalescent nursing home or rest home with nursing supervision.

(ii) Instructors shall 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.

(9) Feeding assistants may be utilized in a licensed chronic and convalescent nursing home or rest home with nursing supervision, provided:

(A) Such facility's training program for feeding assistants is currently approved by the department as provided in section 19-13-D8t (l)(10) of the Regulations of Connecticut State Agencies.

(B) The feeding assistant has successfully completed at least ten hours of training in a state-approved feeding assistant training program, which shall include:

(i) A minimum of eight (8) hours of classroom instruction, including but not limited to:

(a) feeding techniques;

(b) safety and emergency procedures including immediate reporting to a licensed practical nurse or registered nurse in an emergency and emergency measures for choking, including the Heimlich Manuever;

(c) assistance with feeding and hydration;

(d) infection control;

(e) recognizing changes in resident behavior;

(f) appropriate responses to patient behavior;

(g) the importance of reporting behavioral and physical changes to a licensed practical nurse or registered nurse;

(h) communication and interpersonal skills; and,

(i) resident rights.

(ii) At least two (2) hours of clinical practicum under the direct supervision of a registered nurse.

(C) A record of individuals who have successfully completed the training program for feeding assistants is maintained by the training facility and shared with other nursing homes upon request should the feeding assistant seek employment in another nursing home. If the facility hires a feeding assistant who has been trained at another facility, a record of such individual's successful completion of training shall be obtained and maintained.

(D) Feeding assistants shall only assist patients who are fed orally and do not have any complicated feeding problems identified in the individual's medical record. Feeding assistants shall not perform any other nursing or nursing-related tasks.

(i) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations and tube or parenteral/IV feedings.

(E) At no time shall a feeding assistant provide services above the following ratios:

(i) One (1) feeding assistant to feed two (2) residents at one (1) time; or,

(ii) One (1) feeding assistant to assist to cue no more than four (4) residents at one (1) time.

(F) Any patient who is to be fed by a feeding assistant shall be initially and periodically assessed regarding the ability to be fed by a feeding assistant pursuant to sections 19-13-D8t (n)(1)(C) and 19-13-D8t (o)(2)(H) of the Regulations of Connecticut State Agencies and all assessments shall be documented in the patient's individual care plan.

(G) Feeding assistants shall function under the supervision of a licensed practical nurse or registered nurse and shall not be included in nurse staffing requirements and shall not be a substitute for nurse aide staffing pursuant to subsection (m) of section 19-13-D8t of the Regulations of Connecticut State Agencies.

(10) Each licensed chronic and convalescent nursing home and rest home with nursing supervision that elects to conduct a feeding assistant training program shall submit for approval by the department such information on its feeding assistant training program as the commissioner may require, on forms provided by the department. No feeding assistant training program shall commence without the approval of the department. Training conducted pursuant to such training program shall be performed by or under the general supervision of a registered nurse. Licensed practical nurses and certified dietitians may serve as trainers in the feeding assistant training program, under the supervision of the registered nurse.

(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 p.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 p.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 p.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 p.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 transferred 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.
- (8) 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 in accordance with the recommendations of the Advisory Committee on Immunization Practices, established by the United States Secretary of Health and Human Services;
 - (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 sighted patients forty (40) years or over; and
- (E) every ten (10) years, tetanus-diphtheria toxoid immunization following completion of initial series.

(F) Immunization against pneumococcal disease in accordance with the recommendations of the National Advisory Committee on Immunization Practices, established by the Secretary of Health and Human Services.

(9) 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. Tests and procedures shall be provided to the patient given the patient's consent provided no medical reason or contraindication exists, or the attending physician determines that the test or procedure is not medically necessary. Immunizations against influenza and pneumococcal disease shall be provided in accordance with the recommendations of the Advisory Committee on Immunization Practices, established by the United States Secretary of Health and Human Services unless medically contraindicated or the patient objects on religious grounds. Documentation of tests, procedures and immunizations provided or reasons for not providing said tests, procedures and immunization shall be so noted by the attending physician in the 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-535 (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 meet 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.

(6) Emergency Distribution of Potassium Iodide. Notwithstanding any other provisions of the Regulations of Connecticut State Agencies, during a public health emergency declared by the Governor pursuant to section 2 of public act 03-236 and, if authorized by the Commissioner of Public Health via the emergency alert system or other communication system, a chronic and convalescent nursing home and rest home with nursing supervision licensed under chapter 368v of the Connecticut General Statutes that is located within a 10 mile radius of the Millstone Power Station in Waterford, Connecticut, shall be permitted to distribute and administer potassium iodide tablets to facility staff or visitors present at the chronic and convalescent nursing home, or rest home with nursing supervision during such emergency, provided that:

(1) Prior written consent has been obtained by the chronic and convalescent nursing home, or rest home with nursing supervision for such provision. Written consent forms shall be provided by the chronic and convalescent nursing home, or rest home with nursing supervision to each resident, or resident's conservator, guardian, or legal representative currently admitted and to each employee currently employed promptly upon the effective date of this subdivision. Thereafter, written consent forms shall be provided by the chronic and convalescent nursing home, or rest home with nursing supervision to each resident, or resident's conservator, guardian, or legal representative upon admission to such facility and to each new employee upon hire. Such documentation shall be kept at the facility;

(2) Each person providing consent has been advised in writing by the chronic and convalescent nursing home, or rest home with nursing supervision that the ingestion of potassium iodide is voluntary;

(3) Each person providing consent has been advised in writing by the chronic and convalescent nursing home, or rest home with nursing supervision about the contraindications and the potential side effects of taking potassium iodide, which include:

(A) persons who are allergic to iodine should not take potassium iodide;

(B) persons with chronic hives, lupus, or other conditions with hypocomplementemic vasculitis should not take potassium iodide;

(C) persons with Graves disease or people taking certain heart medications should talk to their physician before there is an emergency to decide whether or not to take potassium iodide; and,

(D) side effects including minor upset stomach or rash.

(4) Only those individuals with applicable statutory authority may distribute and administer potassium iodide to residents for whom written consent has been obtained; and,

(5) Potassium iodide tablets shall be stored in a locked storage area or container.

(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 pre-existed 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 (1) 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.

(ii) Elevator vestibules shall have two (2) hour construction with self-closing one and one-half (1½) inch fire rated doors held open by electro-magnetic 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 (4½) 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 (1¹/₂) 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 (1¹/₂) 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 (1¹/₂) 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 non-slip 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; amended March 29, 2001, March 8, 2004, January 4, 2005, May 1, 2007)

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

(a) As used in this section:

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

(2) "IV Admixture" means an IV fluid to which one or more additional drug products have been added;

(3) “IV Fluid” means sterile solutions of 50 ml or more, intended for intravenous infusion but excluding blood and blood products;

(4) “IV therapy” means the introduction of an IV fluid or 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;

(5) “IV therapy program” means the overall plan by which the facility implements, monitors and safeguards the administration of IV therapy to patients;

(6) “IV therapy nurse” means 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 or IV 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) **IV Therapy Programs in Chronic and Convalescent Nursing Homes.** IV Therapy may be administered in a chronic and convalescent nursing home in accordance with the following requirements:

(1) The IV therapy program shall 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 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 IV therapy program pursuant to a physician order may:

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

(B) Deliver an IV fluid or 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 or 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 procedure initiated and made available upon the request of the Commissioner of Public Health. 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.

(Effective May 20, 1985; amended March 8, 2004)

Sec. 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)

Sec. 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 author-

ized 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)

Secs. 19-13-D10—19-13-D11.

Repealed, September 25, 1990.

Sec. 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.

Sec. 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, the 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)

Sec. 19-13-D14. Minimum requirements for licensing maternity hospitals

For the purpose of this section, "maternity hospital" or "lying-in place" means a place into which women are received for professional care because of pregnancy. Each maternity hospital affected by section 19-43 of the general statutes shall comply with the following requirements before a license is issued:

(a) **Medical service.** There shall be a resident physician or consulting physician for each maternity hospital who shall assume responsibility for the general adequacy of medical nursing care rendered in the institution and who shall be available for emergency in case of need, provided a practitioner of a healing art entitled by law to practice obstetrics may conduct a maternity hospital with a resident or consulting practitioner of a healing art licensed to practice surgery.

(b) **Nursing service.** Each maternity hospital shall have a registered nurse in attendance at all times for the mothers and infants and such nurse shall not attend patients on any other service.

(c) **Cleanliness and management.** The building, equipment and surroundings shall be kept clean at all times and the management and operation of the hospital shall be such as reasonably to ensure the health, comfort and safety of the patients.

(d) **Building, space and equipment requirements.** The building, space and equipment requirements for a maternity hospital shall be provided for as follows:

(1) Fire protection. The buildings, equipment and precautions taken to provide for the safety of patients and employees in case of fire shall be approved by the state commissioner of health.

(2) A separate unit. To insure complete segregation of maternity patients and new-born infants from other types of patients, a maternity hospital operated as a part of a general hospital shall be in a separate unit of the institution and either have its own separate sterilization equipment and supplies or be furnished with sterile supplies from a central sterilizing room.

(3) Nursery. Each maternity hospital shall maintain a separate room for a nursery with a bassinet for each baby and one incubator for a premature infant, for every ten or fewer bassinets. This is not to be construed to preclude rooming-in accommodations when the hospital has adequate facilities, including hot and cold running water, for the care of the mothers and infants.

(4) Delivery room. Each maternity hospital shall have a separate delivery room which shall not be used for any patient with an infection.

(5) Space between beds. There shall be a space of at least three feet between beds.

(6) Isolation facilities. A separate room shall be available for the isolation of patients who develop evidence of infection. Any indication of infection shall be reported immediately to the physician who has assumed responsibility for adequacy of care in the institution. Any obstetrical patient with a mouth temperature of 100.4°F. or more (excluding the first twenty-four hours after delivery) for a period longer than twenty-four hours, as well as any other infection which may be contagious irrespective of temperature readings, shall be isolated from other maternity patients. Any infant showing evidence of infection of any kind or any infant exposed to an infected mother shall be removed from the nursery. Isolation technique shall be observed for all such cases.

(7) Temperature. The heating equipment shall be such as will maintain a temperature of not less than 70°F. No oil or gas heater shall be used in a room unless it is directly connected with a flue which opens to the outside air.

(8) Laboratory. There shall be laboratory equipment and reagents necessary to test urine for albumin, sugar and acetone bodies.

(9) Other equipment. Each maternity hospital shall have adequate equipment for resuscitation of infants.

(e) **Records.** A complete record of each case shall be kept which shall include items of information as may be required by the state department of health and shall include all items necessary to fill out a death certificate for the mother and all items necessary to fill out a birth certificate or a death certificate for the baby, together with steps taken in handling the case.

(f) **Required procedure.** The following procedures shall be carried out for each case admitted to a maternity hospital:

(1) Each patient shall be attended by a practitioner of the healing arts licensed to practice obstetrics or by a midwife.

(2) A specimen of blood shall be taken from each patient for the Wasserman or Kahn or similar test and submitted to a laboratory approved by the state department of health, unless the attending physician writes and signs a note in the record that such test is not necessary.

(3) Before removal from the delivery room, each newborn infant shall be marked for identification with a mark which shall not be removed while the child is in the hospital.

(4) All drugs, disinfecting solution and other preparations kept in the institution shall be distinctly and correctly labeled and kept readily available in a place approved by the state department of health.

(5) Section 19-92 of the general statutes reads as follows: “Any inflammation, swelling or unusual redness in the eyes of any infant, either apart from or with any unnatural discharge from the eyes of such infant, occurring at any time within two weeks after the birth of such infant, shall, for the purposes of this section, be designated as ‘inflammation of the eyes of the newborn.’ The professional attendant or other person caring for a newborn infant shall report any such inflammation of the eyes of the newborn to the local director of health within six hours after such condition is observed. The person in attendance at the birth of any infant shall instill into the eyes of such infant, immediately after birth, one or two drops of a prophylactic solution approved by the state department of health. The state department of health shall furnish in a convenient form for such use a prophylactic solution for gratuitous distribution to persons licensed to practice the healing arts or midwifery. Any person who violates any provision of this section shall be fined not less than ten dollars nor more than fifty dollars.”

(g) **Duration of license.** Each license shall terminate on the thirty-first day of December of each year. A license may be revoked at any time for just cause.

Sec. 19-13-D14a.

Repealed, December 23, 1997.

Secs. 19-13-D15—19-13-D16.

Repealed, October 28, 1985.

Sec. 19-13-16a.

Repealed, February 16, 1978.

Secs. 19-13-D17—19-13-D18.

Repealed, October 28, 1985.

Sec. 19-13-D18a.

Repealed, February 16, 1978.

Sec. 19-13-D19.

Repealed, May 19, 1970.

Secs. 19-13-D19a—19-13-D19b.

Repealed, October 28, 1985.

Secs. 19-13-D20—19-13-D39.

Repealed, June 4, 1996.

Sec. 19-13-D40. Donation of eyes for scientific, educational or therapeutic use

(a) **Definitions.** In this regulation to effect the purposes of section 19-139e of the 1965 supplement to the general statutes, insofar as they pertain to eyes, to following words and phrases shall have the following meanings:

(1) Eye bank means an identified special function of a hospital or medical institution having a record system covering the status of the donor’s intent and disposition of the donated tissue, providing storage facilities, carrying cases and solution for in and out transportation and having materials necessary for maintaining bacteriological and pathological control of the tissue;

(2) donor means the person who by written instrument has validly donated his eyes for use after his death;

(3) donee means any Connecticut hospital or medical institution establishing an eye bank approved by the state department of health to receive eyes for assignment for transplantation or for any other scientific, educational or therapeutic use;

(4) donee's agent means any physician, or the agent of any Connecticut hospital or medical institution, cooperating with the donee in the removal, preparation or storage of the donor's eyes, and

(5) recipient means any person eligible to receive a transplantation of eye tissue, or any hospital or medical institution receiving eye tissue for other scientific, educational or therapeutic use.

(b) **Approval of donee.** Any donee shall make annual application in writing over the signature of a responsible executive or staff member to the state commissioner of health for approval as required in section 19-139c of the 1965 supplement to the general statutes. After inspection, the commissioner of health shall notify the hospital or medical institution whether or not the application is approved, which notification shall be kept as part of the permanent records of the eye bank.

(c) **Notification on death of donor.** Upon the death of the donor, his next of kin or other person legally responsible shall forthwith notify the donee, which shall agree to keep such records as the state department of health may require to accomplish the purposes of this section at no expense to the state.

(d) **Priority schedule for distribution.** Each donee shall maintain a priority schedule to ensure that the distribution of available or suitable tissue be made in the following order:

(1) For those purposes that may be specified by the donor in the written instrument, when feasible;

(2) for use of the eye for a living recipient in Connecticut;

(3) for use of the eye outside of Connecticut for a living recipient who is a Connecticut resident;

(4) for use of the eye outside of Connecticut for a living recipient who is a nonresident of Connecticut;

(5) for other medical or educational purposes.

(e) **Procedure and techniques to be approved.** All procedures, equipment and techniques used by a donee or donee's agent in the removal, preparation, storage and transportation of the donor's eyes shall be based upon principles of asepsis and shall meet the approval of the state department of health.

(f) **Fee prohibited.** No fee of any kind may be charged the donor or the recipient except where authorized by statute nor may requests for donations in lieu of a fee be solicited.

(g) **Removal of eyes prohibited, when.** No donor's eyes shall be removed if it is known that a valid gift of the whole of the donor's body has been made unless the donor has expressly indicated to the contrary under the provisions of the written instrument, nor shall any eye be used for any living recipient pursuant to this section when the medical history of the donor or subsequent tests of the enucleated eyes reveal any disease or condition specified by the state department of health as rendering such tissue unfit for such use.

(h) **Instrument for gift.** The written instrument specified in section 19-139e of the 1965 supplement to the general statutes and such additional forms with such instructions as may be necessary to accomplish the purposes of said section shall be prepared or approved by the state department of health.

(i) **Advisory committee.** An advisory committee, consisting of at least four members, of whom at least one shall be an ophthalmologist, one a pathologist and

one a hospital administrator, shall be appointed by the commissioner of health to advise him in the carrying out of the purposes of said section.

(Effective September 1, 1964)

Secs. 19-13-D41—19-13-D42.

Repealed, September 1, 2006.

Sec. 19-13-D43.

Repealed, July 30, 1990.

Sec. 19-13-D43a. Licensure of infirmaries operated by educational institutions

(a) Definitions.

(1) “Accident - Incident” means an occurrence, injury or unusual event which may result in serious injury or death to a patient, or which interrupts services provided by the infirmary;

(2) “Academic year” means the school year as officially designated by the educational institution;

(3) “Applicant” means any individual, firm, partnership, corporation or association applying for or requesting a license or renewal of a license;

(4) “Alterations” means minor remodeling or revision which does not substantially change the physical plant of the infirmary.

(5) “Commissioner” means the Commissioner of the Connecticut Department of Public Health or his designated representative;

(6) “Construction” means the act or process of building;

(7) “Department” means Connecticut Department of Public Health or any duly authorized representative thereof;

(8) “Educational institution” means a place of learning, that is, a school, college, or university;

(9) “Employee” means a person who is employed by an educational institution in return for financial or other compensation;

(10) “Expansion” means an increase in the physical size or dimensions of the infirmary;

(11) “Facility” means the infirmary, as defined in this subsection;

(12) “Faculty” means the teachers and instructors employed by an educational institution;

(13) “Goals” means attainable ends towards which clinical care is directed and focused;

(14) “Governing authority” means the individuals with the ultimate authority and responsibility for the overall operation of the educational institution and the services which it provides;

(15) “Infirmary” means a health care facility operated by an educational institution, which provides evaluation and treatment services for routine health problems and provides overnight accommodations of limited duration for students, faculty and employees of such institution who are receiving short term care and treatment for noncritical illnesses, are recovering from surgery, or require observation, and who do not require the skills and equipment of an acute care hospital;

(16) “Institutional Outbreak” means the occurrence in an institution of cases of illness over a specific time period clearly in excess of normal expectancy. The number of cases indicating an institutional outbreak may vary according to the

etiology, size and type of population exposed, experience with the disease, and time and place of occurrence. An outbreak of disease is an epidemic;

(17) “License” means the form of permission issued by the Department of Public Health that authorizes an educational institution to operate an infirmary;

(18) “Licensee” means the educational institution licensed to operate an infirmary;

(19) “Licensed Capacity” means the maximum number of patients allowed under the school’s license to be admitted to the infirmary for overnight care at any one time;

(20) “Licensed Nursing Personnel” means registered nurses and practical nurses licensed in Connecticut in accordance with Chapter 378, of the Connecticut General Statutes;

(21) “Local Director of Health” means and includes town, city, borough, district, and local director of health, local superintendent and commissioner of health, and any officer or person having the usual powers and duties of a local director of health;

(22) “Medication” means any medicinal preparation including controlled substances, as defined in section 21a-240 of the Connecticut General Statutes;

(23) “Nursing Care Plan” means a written plan documenting a patient’s nursing needs based on the use of the nursing process and includes a written plan to meet these needs;

(24) “On Call” means the continuous availability either in person or by telephone or by telecommunication to personnel who are on duty in the infirmary;

(25) “On Duty” means physically present in the infirmary, awake and alert and able to respond to patient care needs;

(26) “Patient Care Plan” means an overall, interdisciplinary written plan documenting an evaluation of the patients needs, short and long term goals, care and treatment;

(27) “Patient Rights” means those rights to which all patients are entitled by state and federal law;

(28) “Physician” means a doctor of medicine or osteopathy licensed to practice medicine in Connecticut in accordance with Chapters 370 or 371, of the Connecticut General Statutes;

(29) “Practical Nurse” means a person with a license to practice as a practical nurse in Connecticut in accordance with Chapter 378, of the Connecticut General Statutes.

(30) “Quality Care” means that patients receive clinically competent care which meets professional standards, are supported and directed in a planned pattern toward mutually defined outcomes, obtain coordinated service through each level of care, and are taught self-management and preventive health measures with respect to age and level of understanding;

(31) “Registered Nurse” means a person with a license to practice as a professional nurse in Connecticut in accordance with Chapter 378, of the Connecticut General Statutes;

(32) “Renovation” means a major remodeling or revision which substantially changes the physical plant of the infirmary;

(33) “Reportable Disease” means a communicable disease, disease outbreak or other condition of public health significance required to be reported to the department and the local director of health;

(34) “Statement of Ownership and Operations” means a written statement as to the legal owners of the premises and legal entity that operates the facility to be licensed;

(35) “Student” means an individual who is enrolled to attend an educational institution;

(36) “Supervision” means the direct inspection and on site observation of the functions and activities of others in the performance of their duties and responsibilities;

(37) “Vector” means an organism which carries pathogens from one host to another.

(b) Licensure Procedure.

(1) No educational institution shall operate an infirmary without a license issued by the department in accordance with section 19a-491 of the Connecticut General Statutes.

(2) Application for Licensure

(A) Application for the initial granting or renewal of a license to operate an infirmary in an educational institution shall be made in writing on forms provided by the department and shall be signed by the Chief Administrative Officer, Medical Director, and Nursing Director and shall contain the following information:

(i) name and address of education institution;

(ii) location within the education institution of the infirmary;

(iii) type of facility to be licensed;

(iv) number of beds to be licensed;

(v) statement of ownership and operation;

(vi) evidence of compliance with local zoning ordinances and local building codes upon initial application and when applicable;

(vii) a certificate issued by the local fire marshal indicating that an annual inspection has been made and that the infirmary is in compliance with the applicable fire codes;

(viii) a report issued by the department indicating that the annual inspection by a sanitarian has been made and that the infirmary is in compliance with the applicable environmental health codes;

(ix) an organizational chart for the infirmary;

(x) names and titles of the clinical staff employed in the infirmary; and

(xi) statistical information as requested by the department.

(B) An application for license renewal shall be made in accordance with subsection (b) above, not later than October 15th each year.

(3) Issuance and Renewal of Licensure

(A) Upon determination by the department that an infirmary is in compliance with the statutes and regulations pertaining to its licensure, the department shall issue a license or renewal of a license to operate an infirmary in accordance with section 19a-493 of the Connecticut General Statutes as amended.

(B) A license shall be issued in the name of the educational institution and premises as listed on the application. The license shall not be transferable to any other person, institution or corporation.

(C) Each license shall list on its face the location and licensed capacity of the infirmary, the name of the educational institution, and the dates of issuance and expiration.

(D) The license shall be posted in a conspicuous place in the infirmary in an area accessible to the public.

(E) The licensee shall immediately notify the Department of Public Health of any change in the Chief Administrative Officer, Medical Director, or Nursing Director.

(F) The licensee shall notify the department in writing of any proposed change of ownership, location of the infirmary, number of beds, or services provided at least ninety (90) days prior to the effective date of such proposed change. The change shall not become effective without prior written approval by the department.

(4) Suspension, Revocation or Denial of License

(A) The department after a hearing may suspend, revoke, refuse to renew a license or take any other action it deems necessary whenever, in the judgment of the commissioner, the infirmary:

(i) substantially fails to comply with applicable regulations prescribed by the department;

(ii) substantially fails to comply with applicable state, local and federal laws, ordinances, and regulations related to the building, health, fire protection, safety, sanitation or zoning codes; or,

(iii) knowingly furnishes or makes any false or misleading statements to the department in order to obtain or retain the license.

(B) Any educational institution may appeal such suspension, revocation or denial in accordance with Section 19a-501 of the General Statutes of Connecticut and Sections 19-2a-1 through 19-2a-41 inclusive of the Regulations of Connecticut State Agencies.

(C) Refusal to grant the department access to the infirmary or to those infirmary records relating to matters concerning the department in the discharge of its duties shall be grounds for denial or revocation of the infirmary's license. If, after a hearing, the commissioner determines that the department does have the right to access these records, the school's refusal to grant access shall constitute a substantial failure to comply.

(5) Surrender of license

(A) At least thirty (30) days prior to the voluntary termination of infirmary services the department shall be notified in writing by the educational institution of its intention.

(B) The educational institution shall notify those who are eligible to use the infirmary at least thirty (30) days prior to any one of the actions in subsections (i) and (ii) below. The individuals to be notified shall be identified as part of the educational institution's written policies:

(i) the voluntary surrender of an infirmary license by the institution;

(ii) the department's order of revocation; or the department's refusal to renew the license; or the department's suspension of the license.

(C) The license shall be surrendered to the department within seven (7) days after voluntary termination of operation, or revocation or suspension of the infirmary license, unless otherwise ordered by the commissioner.

(c) **Administration.**

(1) Governing Authority

(A) The governing authority of the educational institution shall be the governing authority for the licensed infirmary and shall be responsible for compliance with relevant regulations.

(B) The governing authority shall exercise general direction over the establishment and implementation of policies for the licensed infirmary and may delegate formulation and enactment of procedures in compliance with all local, state, and federal laws. Such direction and policies shall include but not be limited to:

(i) appointment of a chief administrative officer whose qualifications, authority and duties are defined in writing; and notification of the department of any change in appointment;

(ii) provision of a safely equipped physical plant and maintenance of the infirmary and services in accordance with all applicable local, state and federal laws;

(iii) establishment of an organizational chart which clearly defines the lines of responsibility and authority relating to the management and maintenance of the infirmary;

(iv) establishment of mechanisms and documentation of annual review of all infirmary policies and procedures;

(v) documentation of all current agreements with consultants, practitioners, agencies and providers required on a regular basis by the infirmary in the delivery of services. These agreements shall be considered in force unless terminated by one of the parties.

(2) Chief Administrative Officer

(A) Each licensed infirmary shall have a chief administrative officer who is accountable to the governing authority for:

(i) the general operation of the infirmary;

(ii) the appointment of a medical director and notification to the department of any change in this position;

(iii) the appointment of a nursing director and notification to the department of any change in this position; and

(iv) filing all materials for licensure or relicensure.

(B) The chief administrative officer may delegate responsibilities for the operation of the infirmary to others as appropriate.

(d) **Staffing.** Each infirmary shall have qualified staff to meet the needs of patients. These shall include:

(1) Medical Director

(A) There shall be a licensed physician or licensed osteopath designated as the medical director.

(B) The medical director, with the approval of the chief administrative officer, shall designate another licensed physician to act in his/her place during his/her absence.

(C) The duties of the medical director shall include, but not be limited to:

(i) visiting the infirmary as frequently as clinically indicated; and

(ii) being available by telephone twenty-four (24) hours per day and being available to respond promptly in an emergency.

(D) The medical director shall assume responsibility for:

(i) the medical care rendered in the infirmary;

(ii) developing criteria by which he/she can determine the admission or denial of admission of a patient based on the infirmary's ability to provide needed care;

(iii) proper care and inventory of all drugs in accordance with section 21a-254 of the Connecticut General Statutes.

(iv) the medical record including the proper entry of medical and clinical services provided;

(v) receiving reports from the nursing director on significant clinical developments in patients' care; and

(vi) authorizing hospital care, medical referrals, and other clinical services as needed for patients in the infirmary.

(2) Nursing Director - There shall be a full-time licensed registered nurse designated as the nursing director for the infirmary and whose responsibilities shall include, but not be limited to:

(A) the nursing care provided to patients in the infirmary;

(B) determining and arranging staffing when there are patients in the infirmary;

(C) participating in staff recruitment and selection;

(D) notifying the department of changes in nursing staff with the exception of those employed directly by a nursing pool;

(E) orienting, supervising and evaluating the infirm nursing staff;

(F) proper maintenance of clinical records; and

(G) coordinating the services provided to patients in the infirmary.

(3) Nursing Staff

(A) There shall be a licensed nurse on duty whenever there is a patient in the infirmary.

(B) When the infirmary is open, there shall be a licensed registered nurse or a licensed physician on call.

(C) When the infirmary is closed, there shall be a plan for alternate care.

(D) Staff Schedule:

(i) There shall be a staff schedule and assignment of duties to assure twenty-four (24) hour coverage sufficient to meet the needs of patients in the infirmary.

(ii) There shall be a licensed nurse designated in charge for each shift when there is a patient in the infirmary.

(4) Nurse's Aides

(A) Nurse's Aides may be employed to care for patients in the infirmary under the direction of a licensed nurse.

(B) A nurse aide's preparation or work experience shall include one of the following:

(i) A certificate of satisfactory completion of an approved nurse's aide training program in accordance with section 19-13-D8t (1) of the Regulations of Connecticut State Agencies; or,

(ii) evidence of completion of:

(aa) a vocational nurse's aide program by the State Department of Education; or,

(bb) a minimum of one (1) year of continuous, full-time or full-time equivalent work experience as a nurse aide providing personal care of patients under the supervision of a registered nurse in a general hospital, hospice, chronic disease hospital, chronic and convalescent nursing home, and completion of a nurse's aide competency evaluation.

(iii) One year of continuous employment as a nurse's aide in the same licensed infirmary in an educational institution prior to August 1, 1990.

(C) Nurse's aides may provide care only when:

(i) there is a licensed nurse on duty; and,

(ii) there is a written plan for the nursing care to be provided by the nurse's aide, which does not include skilled nursing care, medication administration, or treatments, and which is legally permissible and within the competence of the nurse's aide.

(D) Nurse's aides may not assess and/or admit patients to the infirmary or discharge patients from the infirmary.

(5) A homemaker-home health aide as defined in section 19-13-D80 (n) of the Regulations of Connecticut State Agencies may provide care on the same basis as a nurse's aide in accordance with subdivisions (4)(C) and (4)(D) of this subsection.

(e) **Physical Plant**

(1) The standards established by the following sources for the construction, renovation, alteration, expansion, conversion, maintenance and licensure of infirmaries, as they are amended from time to time, are incorporated and made a part of these regulations by reference:

(A) State of Connecticut Basic Building Code;

- (B) State of Connecticut Fire Safety Code;
- (C) State of Connecticut Public Health Code;
- (D) Local Codes and Ordinances.

(2) Plans and specifications for new construction and alteration, addition or modification of an existing structure are subject to approval by the department on the basis of compliance with the Regulations of Connecticut State Agencies after the approval of such plans and specifications by the local building inspector, local director of health or designee, and local fire marshal prior to the start of construction.

(3) Waiver

(A) The commissioner may waive provisions of subdivisions (4) and (5) of this subsection related to the environment and physical plant in these regulations, if the commissioner determines that meeting these provisions is not possible and such waiver would not endanger the life, safety or health of patients in the infirmary. 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 finding that the health, safety or welfare of any patient has been jeopardized.

(B) Any infirmary requesting a waiver shall apply in writing to the department. Such application shall include:

- (i) the name and address of the infirmary including the name of the Chief Administrative Officer and the contact telephone number;
- (ii) the specific regulations for which the waiver is requested;
- (iii) the level of care which the infirmary provides;
- (iv) the maximum patient capacity;
- (v) The reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the infirmary upon enforcement of the regulation;
- (vi) the specific relief requested;
- (vii) the length of time for which the waiver is requested;
- (viii) the impact of a waiver on the care provided;
- (ix) alternative methods for meeting regulatory requirements; and
- (x) any documentation which supports the application for waiver.

(C) In consideration of any application for a waiver, the commissioner may ask that additional information be provided.

(D) The department may request a meeting with the applicant in conjunction with the waiver application.

(E) The applicant may request a meeting with the department in conjunction with the waiver application.

(F) Should the waiver be denied, the applicant may request a hearing. This hearing shall be held in conformance with Chapter 54 of the Connecticut General Statutes and department regulations.

(G) A waiver shall be granted for no more than two years at a time and may be renewed subject to approval by the commissioner.

(4) General Requirements

(A) The infirmary shall be of structurally sound construction and equipped, so as to sustain its safe and sanitary characteristics to prevent or minimize all health and fire hazards.

(B) The building, equipment and services shall be maintained in a good state of repair. A maintenance program shall be established which ensures that the interior,

exterior and grounds of the building are maintained, kept clean and orderly, and free from accumulations of refuse, dilapidated structures, and other health hazards.

(C) Sleeping and personal care space:

(i) In existing infirmaries there shall be clearly defined sleeping and personal care areas which are sufficient in size to comfortably accommodate the approved capacity of patients.

(ii) In newly constructed infirmaries and in infirmaries renovated after August 1, 1990, a physical environment, including opportunities for privacy, in clearly defined sleeping and personal care spaces shall be provided. This area shall be sufficient in size to comfortably accommodate the approved capacity of patients.

(D) In newly constructed infirmaries and in infirmaries renovated after August 1, 1990, vertical transportation shall be provided in multilevel facilities by an elevator if handicapped accessible facilities are not otherwise available.

(E) Water supply, food service and sewage disposal facilities shall be in compliance with other applicable sections of the Public Health Code.

(F) Notification of new construction, expansion, renovation or conversion, indicating the proposed use and accompanied by a written narrative shall be submitted to the Department of Public Health, at least sixty (60) days prior to start of construction.

(C) Notification of alteration indicating the proposed use accompanied by a written narrative shall be submitted to the Department of Public Health at least thirty (30) days prior to the start of construction.

(5) Basic Requirements

(A) All patients, personnel, visitors, and emergency vehicles shall have access to infirmary buildings and grounds.

(B) Established walkways shall be provided for each entrance and exit leading to a driveway or street and must be properly maintained.

(C) The following administration and public areas shall be provided:

- (i) storage space for office equipment, supplies and records;
- (ii) a private area in which to conduct patient interviews; and
- (iii) a waiting area for patients and visitors.

(D) The following nursing service areas shall be provided:

- (i) a designated nursing station;
- (ii) twenty-four (24) hour telephone service including an outside line;
- (iii) emergency telephone numbers shall be posted and shall include at least the following:

- (aa) medical director;
- (bb) substitute physicians;
- (cc) local director of health;
- (dd) hospital to use;
- (ee) ambulance service(s);
- (ff) school security;
- (gg) fire department;
- (hh) police department (local and state);
- (ii) nurse on call and substitutes;
- (jj) administrator on call;
- (kk) institution service personnel;
- (ll) poison control center (local and state);

(iv) a room with a toilet and sink for use by the clinical personnel. For newly constructed infirmaries and in infirmaries renovated after August 1, 1990, this room shall be adjacent to the nursing station;

(v) a medication preparation area near the nursing station or within the treatment room;

(vi) a clean linen storage area;

(vii) an equipment storage area;

(viii) in newly constructed infirmaries and in infirmaries renovated after August 1, 1990, there shall be a patient treatment room of at least eighty (80) square feet which contains a work counter, storage facilities and a handwashing sink;

(ix) in newly constructed infirmaries and in infirmaries renovated after August 1, 1990, there shall be a nourishment station which shall contain a sink, work counter, refrigerator, storage cabinets, an appliance for heating food, and be equipped for serving nourishment.

(E) Infirmary bedrooms shall meet the following requirements:

(i) there shall be no more than four (4) beds per bedroom. Bunk beds shall not be used;

(ii) in newly constructed infirmaries and in infirmaries renovated after August 1, 1990, there shall be a minimum of three (3) feet of space between and around beds on three sides in multi-bed rooms. In existing infirmaries there shall be a minimum of three (3) feet of space between beds in multi-bed rooms.

(iii) all patient rooms shall open to a common corridor which leads to an exit;

(iv) each infirmary bedroom shall be on an outside wall. This outside wall must have either a window or door capable of being opened from inside;

(v) all windows which open to the outside shall be equipped with sixteen (16) mesh screening;

(vi) no room which opens into the food preparation area or necessitates passing through the food preparation area to reach any other part of the infirmary shall be used as a bedroom;

(vii) separate patient rooms shall be provided for males and females;

(viii) the room furnishings for each patient shall include a single bed with a mattress, a washable mattress pad or cover, a reading light, a bedside cabinet or table, a bedside tray table, and an available chair. In newly constructed infirmaries and in infirmaries renovated after August 1, 1990, a moisture-proof mattress shall be provided.

(ix) there shall be an area available for the storage of patients' clothing. In newly constructed infirmaries and in infirmaries renovated after August 1, 1990, there shall be a closet or wardrobe available to hang patient clothing;

(x) no smoking shall be allowed in the infirmary;

(xi) the use and maintenance of electrical cords, appliances, and adaptors shall be in full compliance with state codes;

(xii) in existing infirmaries each patient room shall have access to a sink with hot and cold running water which sink is not used for food or medication preparation. In newly constructed infirmaries and in infirmaries renovated after August 1, 1990, each patient room shall have a sink with hot and cold running water.

(xiii) The bedside of each patient shall have a method for calling the nurse. In newly constructed infirmaries and in infirmaries renovated after August 1, 1990, the call system shall be of the electronic type.

(F) Toilet Facilities:

(i) One toilet room shall be directly accessible for each six persons without going through another bedroom; in addition to a toilet, each toilet room shall be equipped with a sink which has hot and cold running water, (unless such is available in each

patient room) mirror, toilet tissue, soap, single use disposable towels and a covered waste receptacle.

(ii) In newly constructed infirmaries and in infirmaries renovated after August 1, 1990, on each floor there shall be a minimum of one toilet room, which is accessible to physically handicapped persons and includes a toilet and one handwashing sink on each floor.

(iii) Each toilet room shall have a method for calling the nurse. In newly constructed infirmaries and in infirmaries renovated after August 1, 1990 the call system shall be of the electronic type.

(G) Bathing facilities

(i) In existing infirmaries an area for bathing shall be available on each infirmary floor.

(ii) In newly constructed infirmaries and in infirmaries renovated after August 1, 1990, there shall be one bathtub and shower provided on each infirmary floor.

(iii) One shower or bathtub shall be provided for each eight patients or fraction thereof. Each bathtub and shower must be provided with some type of non-slip walking surface.

(iv) All toilet and bathing facilities shall be well lighted, and ventilated to the outside atmosphere.

(v) In newly constructed infirmaries and in infirmaries renovated after August 1, 1990, all toilet and bathing facilities shall be mechanically ventilated to the outside atmosphere.

(vi) If a bathroom is adjacent to a public area, it must be equipped with a self closing door.

(vii) When bathing facilities are separate from the toilet facilities, there shall be a method for calling the nurse. In newly constructed infirmaries and in infirmaries renovated after August 1, 1990 the call system shall be of the electronic type.

(H) Each patient shall be supplied with linen sufficient to meet his needs. There shall be sufficient linen available for three (3) times the licensed capacity of the infirmary.

(L) Environmental Requirements:

(i) All areas used by patients shall have ambient air temperatures within a range of 68 degrees F. and 72 degrees F.

(ii) The hot water heating equipment must deliver hot water at the tap, the temperature of which shall be within a range of 110 degrees F. to 120 degrees F. It shall have the capacity to deliver the required amounts at all times.

(iii) Only central heating or permanently installed electric heating systems shall be used. Portable space heaters are prohibited.

(iv) All doors to patient bathrooms, toilet rooms and bedrooms shall be equipped with hardware which will permit access in an emergency.

(v) Walls, ceilings and floors shall be maintained in a state of good repair and be washable or easily cleanable.

(vi) Hot water or steam pipes located in areas accessible to patients shall have adequate protective insulation which is maintained, safe and in good repair.

(vii) Each infirmary floor shall be provided with a telephone that is accessible to staff for emergency purposes.

(viii) Emergency telephone numbers shall be posted in an area adjacent to the phone and shall be accessible to all individuals in the infirmary.

(ix) Provisions shall be made to assure an individual's privacy in the bathroom, bathtub and shower areas.

(x) All spaces occupied by people, equipment within buildings, approaches to buildings, and parking lots shall have adequate lighting.

(xi) In existing infirmaries there shall be adequate lighting in patient rooms and toilet rooms shall have at least one light fixture switched at the entrance. In newly constructed infirmaries and in infirmaries renovated after August 1, 1990, all rooms shall have adequate general and night lighting, and all bedrooms and toilet rooms shall have at least one light fixture switched at each entrance.

(xii) Items such as drinking fountains, telephone booths, vending machines, and portable equipment shall not reduce the required corridor width. At all times corridors shall be maintained clear of combustibles and of obstructions to immediate egress.

(xiii) All doors to patient bedrooms and all means of egress shall be of a swing type.

(xiv) There shall be effective measures taken to protect against the entrance into the residence or breeding on the premises of vermin. During the season when vectors are prevalent, all openings into outer air shall be screened with a minimum of sixteen (16) mesh screening and doors shall be provided to prevent the entrance of vectors.

(xv) Emergency lighting shall be provided for all means of egress, nursing stations, treatment rooms, medication preparation areas and patient toilet rooms.

(xvi) Storage areas, basements, attics and stairwells must be properly maintained and in good repair, clean and uncluttered.

(xvii) Operational safety procedures for emergency egress shall be developed for the safety of patients and personnel and practiced with staff and documented at least twice per year.

(xviii) There shall be no pesticide storage in the infirmary. Potentially hazardous substances in the infirmary shall be stored in a locked area.

(xix) The fire extinguishers shall be maintained, and inspected annually. They shall be hung in a conspicuous location.

(xx) Sinks used by staff in medication and patient treatment areas shall be equipped with wrist blade handles, soap, and a paper towel dispenser and a waste receptacle.

(xxi) In newly constructed infirmaries and in infirmaries renovated after August 1, 1990, there shall be a sink in each patient room equipped with wrist blade handles, soap, and a paper towel dispenser and a waste receptacle.

(xxii) In existing infirmaries there shall be smoke detectors in all patient bedrooms or in the infirmary corridors. In newly constructed infirmaries and in infirmaries renovated after August 1, 1990, an automatic smoke detection system shall be installed in all patient bedrooms and corridors and this system shall be interconnected with the fire alarm system and installed in accordance with the State Fire Safety Code.

(f) Nutrition and Dietary Services.

(1) Nutrition Services

(A) Each infirmary shall provide evidence that the dietary needs of patients are being met.

(B) Unless medically contraindicated, the infirmary shall have the potential to serve at least three (3) meals daily.

(C) The infirmary shall provide special utensils to assist patients in eating when necessary.

(2) Dietary Facilities

(A) If food preparation is provided on the infirmary premises each infirmary shall have its own preparation area which includes space and equipment for storage, preparation, assembling and serving food, cleaning of dishes and disposal of garbage.

(B) Food preparation areas shall be separate from other areas and large enough to allow for adequate equipment to prepare and store food properly;

(C) All equipment and appliances shall be installed to permit thorough cleaning of the equipment, the floor and the walls around them. The floor surface shall be of non-absorbent easily cleanable material;

(D) If food is prepared in the infirmary and nondisposable equipment and dishes are used, a dishwashing machine shall be provided;

(E) A sink with both hot and cold running water, soap, paper towels, and a covered waste receptacle shall be provided in the food preparation area;

(F) On school grounds there shall be a three day supply of food available for the infirmary;

(G) Functional refrigerators and freezers with thermometers shall be provided for the storage of food to meet the needs of the patients;

(H) Trash shall be stored in covered receptacles adequate in size and number outside the building housing the infirmary;

(I) A means of ventilation for the food preparation areas shall be provided;

(J) In newly constructed infirmaries and in infirmaries renovated after August 1, 1990, mechanical ventilation shall be provided in all food preparation areas.

(K) Dietary facilities and procedures shall be in accordance with other applicable sections of the Regulations of Connecticut State Agencies.

(g) Service Operations.

(1) Policies and Procedures. There shall be a policy and procedure manual implemented for the infirmary which shall be available to staff at all times, complied with, and reviewed annually.

(2) Each infirmary shall implement written policies and procedures governing the admission and discharge of patients and the delivery of services which shall include but not be limited to:

(A) the admission process including admission criteria by which the medical and nursing staff shall decide the admission or denial of admission of a patient based on the infirmary's ability to provide care;

(B) the discharge process including discharge criteria; and

(C) the referral process including follow up.

(3) There shall be a current copy of the Regulations of Connecticut State Agencies available in the infirmary.

(4) Personnel Practices

(A) Each infirmary shall develop and implement policies and procedures governing the orientation and supervision of infirmary staff.

(B) Job descriptions for each infirmary staff position shall include: a description of the duties to be performed; the supervision which will be given; the minimum qualifications for the position; and the effective or revision date.

(C) Pre-employment and periodic physical examinations, including tuberculin testing and a physician's statement that the infirmary employee is free from communicable disease, shall be required of all infirmary employees.

(D) Personnel files for all employees who provide service in the infirmary shall include the following:

(i) educational preparation and work experience;

(ii) current licensure, registration or certification where applicable;

(iii) a record of health examination(s).

(5) Records.

(A) Each infirmary shall maintain a complete medical record for each patient admitted to the infirmary. The record shall be accessible to the infirmary staff at all hours. It must include but not be limited to:

- (i) identification data;
- (ii) an admission history and physical assessment;
- (iii) specific physician treatment orders;
- (iv) written authorization for medical care and treatment;
- (v) for underage patients, documentation of notification of parent or guardian of infirmary admission;
- (vi) a patient care plan based on the patient assessment;
- (vii) nurses notes which include current condition, changes in patient condition, treatments and responses to treatments;
- (viii) documentation of all patient care, patient teaching and services provided or refused by the patient and progress made toward goals and objectives in accordance with the care plan;
- (ix) laboratory test results;
- (x) a record of medications administered including the name and strength of the drug, route and time of administration, dosage and if ordered "as needed" the reason for administration and patient response/result observed;
- (xi) a record of immunizations in accordance with section 10-204a-4 of the Regulations of Connecticut State Agencies.
- (xii) a written discharge summary which indicates the patient's progress, the level of improvement or lack of it, the departure plan, and follow up arrangement, which is signed by the medical director or attending physician within seven (7) days after discharge;
- (xiii) for emergency purposes a record is to be maintained identifying parents and or responsible persons including: name(s) and address, home and business; and telephone numbers, home and business;

(B) Medical records must be kept secure and in a confidential location for seven (7) years after a student is no longer enrolled in or employee or faculty member employed at the educational institution.

(6) Patient Rights. Each infirmary shall have a written:

- (A) description of available services including any charges or billing mechanisms;
- (B) policy which it must implement regarding access to patient records, including an explanation of the confidential treatment of all patient information in infirmary records and the requirement for written consent for release of information to persons not otherwise under law allowed to receive it;
- (C) a list of the names of the persons supervising the medical and nursing care provided in the infirmary and the manner in which those persons may be contacted;
- (D) procedure for registering complaints re: the infirmary with:
 - (i) the school; and
 - (ii) the commissioner.
- (h) **Emergency Preparedness.**

(1) Each infirmary shall formulate, and implement when necessary, a plan for the protection of the patients in the event of fire or other disaster and for their evacuation when necessary to include:

- (A) written evacuation plan instructions and diagrams for routes of exit;
- (B) fire drills conducted as often as the local fire marshal recommends, at irregular intervals during the day, evening and night but not less than quarterly;

(C) assignment of each staff member to specific duties in the event of disaster or emergency;

(D) written plans for the provision of temporary physical facilities to include shelter and food services in the event the infirmary becomes uninhabitable due to disaster or emergency;

(E) annual review by the local fire marshal of the plans written in accordance with this subparagraph.

(2) Documentation shall be submitted to the department annually that all employees have been instructed and kept informed of their duties and responsibilities and that all activities required by this subsection have been completed.

(i) **Infection Control.** Each infirmary shall develop an infection prevention, surveillance and control program which shall include antiseptic technique, isolation policies and procedures and patient education.

(1) There shall be a method to monitor, evaluate and report documented or suspect cases of reportable diseases, as specified in sections 19a-36-A3 and 19a-36-A4 of the Regulations of Connecticut State Agencies, and institutional outbreaks of illness.

(2) Areas shall be provided for isolation of patients as necessary.

(3) There shall be regularly scheduled inservice education programs for staff regarding infection prevention, surveillance and control scheduled at least yearly. Documentation of these programs and attendance shall be available to the department upon request.

(j) **Handling, Storage, and Administration of Medications and Pharmaceuticals.**

(1) In accordance with Chapter 420b of the Connecticut General Statutes, the medical director is responsible for the proper care and inventory of all drugs used in the infirmary.

(2) All medications shall be administered by licensed nurses or other health care practitioners licensed in this state with statutory authority to administer medications.

(3) Orders for the administration of medications shall be in writing, signed by the patient's physician or dentist and in compliance with the infirmary's written policy and procedure.

(A) Medications shall be administered only as ordered by the patient's physician or dentist and in compliance with the laws of the State of Connecticut

(B) Orders shall include at least the name of the medication, dosage, frequency, duration and method of administration and, if ordered "as necessary," the reason for use.

(4) Each infirmary shall have written policies and procedures pertaining to drug control. All unused, discontinued or obsolete medications shall be removed from storage areas and, at the discretion of the medical director, either sent home with the patient or set aside for destruction.

(5) Drugs used in the infirmary shall meet standards established by the United States Pharmacopoeia and shall be stored so as to ensure their proper purity and strength.

(6) Records shall be maintained of all controlled substances in a manner and form prescribed by Chapter 420b of the Connecticut General Statutes.

(7) The area and the equipment necessary for handling, storing and administering drugs shall be kept clean, adequately lighted and ventilated and shall be maintained in good order and shall be used exclusively for this purpose.

(k) **Accident and Incident Reports.** The licensee shall report to the department any occurrence, injury or unusual event which has caused or resulted in, or may

cause or result in, serious injury or death to a patient, or which interrupts, or has the potential to interrupt, services provided in the infirmary.

(1) Classification. Accident/incident reports to the department concerning events occurring in the infirmary shall employ the following classification of such events:

(A) Class A: One which has caused or resulted in, or has the potential to result in, serious injury or death to a patient;

(B) Class B: One which has interrupted, or has the potential to interrupt, the services provided in the infirmary.

(2) Report. The chief administrative officer or designee shall report any Class A or Class B accident or incident immediately by telephone to the department and confirm by written report within seventy-two (72) hours of said event.

(3) Each written report shall contain the following information:

(A) Date of report;

(B) name of the infirmary as stated in the license;

(C) licensed bed capacity;

(D) date of event, incident, or occurrence;

(E) the location, nature and a brief description of the event; the individuals affected; the action taken; and disposition;

(F) if the affected individual was a patient in the infirmary at the time of the reported event:

(i) date of admission;

(ii) current diagnosis;

(iii) physical and mental status prior to the event;

(iv) physical and mental status after the event.

(G) The name of the physician consulted, if any, time physician was consulted, and a report summarizing any subsequent physical examination including findings and orders.

(H) The names of any witnesses to the event, incident or occurrence.

(I) Any other information deemed relevant by the reporting authority.

(J) The signature of the person who prepared the report and the chief administrative officer.

(5) The chief administrative officer or designee shall submit subsequent reports, if applicable, relevant to any accident, event or occurrence previously reported.

(l) **Intravenous Therapy.** Intravenous therapy (I.V.) is not required. If the licensee chooses to allow intravenous therapy to be provided, the following shall apply. When used in section 19-13-D43a of the Regulations of Connecticut State Agencies:

(1) Definitions.

(A) "I.V. Fluid" means sterile solutions of 50 ml or more, intended for intravenous infusion but excluding blood and blood products.

(B) "I.V. Admixture" means an I.V. fluid to which one or more additional drug products have been added.

(C) "I.V. Therapy" means the introduction of an I.V. fluid/I.V. 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 infirmary's medical director.

(D) "Administer" means to initiate the venipuncture and deliver an I.V. fluid/admixture into the blood stream via a vein; and to:

(i) care for the venipuncture site

(ii) monitor the venipuncture site and the therapy

(iii) terminate the procedure

(iv) record pertinent events and observations.

(E) “I.V. Therapy Nurse” means a registered nurse, licensed to practice in Connecticut who is qualified by education and training to administer an I.V. fluid/admixture and has demonstrated proficiency in the theoretical and clinical aspects of I.V. therapy.

(F) “I.V. Therapy Program” means the overall plan by which the infirmary will implement, monitor and safeguard the administration of I.V. therapy to patients.

(2) I.V. therapy may be administered in a licensed infirmary in an educational institution provided the infirmary obtains written approval from the commissioner, in accordance with section 19-13-D8u (c) of the Regulations of Connecticut State Agencies.

(3) Registered nurses who provide I.V. fluid therapy in the infirmary shall have had training through instruction and supervised clinical experience in I.V. fluid therapy.

(4) The infirmary shall develop and implement written policies, procedures and standards of care for the safe administration of I.V. therapy to all patients receiving such treatment. These documents are subject to review and approval by the department as a part of the commissioner’s written approval in subdivision (2) of this subsection.

(A) a description of the objectives, scope, and limitation of the therapy to be provided;

(B) identification of the person(s) in the infirmary responsible for the direction, supervision, and control of I.V. therapy administration. Alternates shall be named in his/her absence;

(C) requirements for the education, training, supervision, in-service education, continuing education, and evaluation of all personnel participant in the administration of I.V. therapy;

(D) specific protocols related to physician orders including but not limited to the volume and type of solution, name and dosage of admixture, start date, frequency, hourly flow rate, renewal/termination date, and monitoring parameters as indicated. Each patient’s plan of care shall include the protocol necessary to carry out the I.V. therapy orders in the infirmary including the frequency of contact with the physician;

(E) protocols for the safe administration, monitoring and termination of I.V. therapy including the procurement of equipment and supplies and the safe preparation, labeling, and handling and disposal of I.V. admixtures and equipment, and infection prevention and control procedures.

(F) I.V. therapy related complications, medication errors, early recognition of the signs and symptoms of sepsis, acute untoward reactions, and appropriate intervention in a timely manner;

(G) emergency precautions and procedures;

(H) documentation and charting procedures which shall include the following:

(i) the date and time of initiation of the I.V. therapy;

(ii) name of the person initiating the therapy;

(iii) the location of the I.V. therapy site;

(iv) the type and gauge of the catheter used;

(v) the type and volume of the solution and admixture(s), including dosages;

(vi) the condition of the I.V. site

(vii) the patient teaching plan and the response of the patient;

(viii) termination, date and time;

(ix) outcome of the therapy and, if any, the complications encountered.

(I) Delivery of I.V. fluid/I.V. admixture(s) via a central line may be done only by a registered nurse under specific protocols.

(5) There shall be a registered nurse on duty during I.V. therapy to:

- (A) care for the site;
- (B) monitor the site and the therapy;
- (C) record pertinent events and observations;
- (D) terminate peripheral vein lines.

(6) There shall be a mechanism in place in the infirmary for ongoing review of the effectiveness and safety of the program and equipment which includes problem identification, corrective action and documentation of same. It is subject to prior review and approval by the department as a part of the commissioner's written approval in subdivision (2) of this subsection.

(7) Only a qualified I.V. therapy nurse may initiate a venipuncture in a peripheral vein for the purpose of delivering I.V. fluid/I.V. admixture(s) into the blood stream. Only a licensed physician may initiate or terminate a central vein access.

(8) There shall be no changes in the approved protocols developed for the I.V. therapy program without the written approval of the commissioner or his/her designee.

(9) Upon determination of compliance with these regulations, approval by the commissioner to participate in an I.V. therapy program shall be renewed at the time of the infirmary's license renewal. Approval to participate in the program may be revoked at any time for failure to comply with these regulations.

(Effective July 30, 1990; amended September 13, 2001)

Sec. 19-13-D44. Industrial health facilities

(a) **Physical facilities.** An industrial health facility shall: (1) Be located in a relatively quiet area readily accessible to employees and transportation; (2) be sufficiently spacious, properly ventilated, heated, lighted and kept clean at all times; (3) contain a sink with hot and cold running water with a skin cleansing agent and disposable towels. Toilet facilities shall be provided in the industrial health facility or nearby. If located nearby, the toilet facilities shall be on the same level or floor.

(b) **Personnel.** (1) Physicians. A medical director shall be appointed who shall be a physician licensed in Connecticut. The medical director shall be responsible for the active professional direction and supervision of all personnel providing health services. The medical director shall provide adequate written medical directives, i.e., standing orders, for all personnel providing health services, which directives he shall review and sign at least annually. The medical directives shall be kept in the industrial health facility. The medical director and, when necessary, another physician or physicians shall visit the industrial health facility regularly in accordance with an established schedule as frequently and for as long a period of time as necessary. The medical director or another physician or physicians shall be on call when employees eligible to receive health services in the industrial health facility are working. (2) Registered nurses. Sufficient registered nurses shall be employed to meet the requirements of the health services provided. (3) Other personnel. Other personnel sufficient to meet the requirements of the health services provided shall be employed. At least one individual who has completed successfully the advanced American Red Cross first-aid course or the equivalent shall be on duty to provide first-aid services whenever a registered nurse or a physician is not on duty in the industrial health facility and employees eligible to receive services are working in the commercial or industrial establishment.

(c) **Equipment.** Equipment adequate for the number of employees to be served and the types of health services offered shall be provided.

(d) **Supplies.** Supplies adequate for the number of employees to be served and the types of health services offered shall be provided.

(e) **Medical records.** (1) **Completeness.** A medical record shall be started for each individual who receives health services. The medical record shall contain all medical health related reports and letters received from laboratories, physicians and others. An entry shall be made for every visit of such person to the industrial health facility. All treatments administered shall be recorded, dated and signed by the individual who administered the treatment. A daily statistical record shall be kept of the services provided in the industrial health facility and kept for at least eighteen months.

(2) **Confidentiality.** Medical records shall be confidential except for cases involving claims under the Workmen's Compensation Act and except that the medical director shall disclose or authorize the disclosure of information as required by law and may disclose or authorize the disclosure of information to responsible individuals when he believes such disclosure is necessary for the best interest of the employee, or when written consent is received from the employee.

(3) **Storage and security.** All current medical records shall be kept in locked files in the industrial health facility under control of the medical director. Noncurrent medical records and medical records regarding former employees shall be kept in locked files under control of the medical director for at least three years.

(f) **X-ray services.** If diagnostic x-ray services are provided in the industrial health facility, the requirements of the public health code shall be complied with. The x-ray equipment shall be operated by adequately trained individuals. No x-ray examination shall be performed unless specifically ordered by a physician.

(g) **Drugs.** (1) **Definitions.** (A) "Administer" to give, distribute, leave with, or deliver drugs to an employee in amounts to satisfy the needs of the employee for a time period not greater than the number of hours in the employees' work shift. (B) "Controlled drug" means a controlled drug as defined in section 19-443 (6) of the 1969 supplement to the general statutes. (C) "Dispense" means to give, distribute, leave with, or deliver drugs to an employee in amounts to satisfy the needs of the employee for a time period greater than the number of hours in the work shift. (D) "Manufacturer of drugs" means a person who has complied with state and federal requirements regarding the manufacture of drugs. (E) "Narcotic drug" means a narcotic drug as defined in section 19-433 (18) of the 1969 supplement to the general statutes. (F) "Prescription drug" means a drug which is not permitted by federal drug laws to be sold, administered or dispensed without a prescription or written order from a licensed practitioner. (G) "Licensed pharmacy" means a pharmacy licensed in accordance with the provisions of chapter 382 of the general statutes. (H) "Wholesaler of drugs" means a person who has complied with the state and federal requirements regarding the wholesaling of drugs.

(2) **Procurement.** Prescription drugs, including non-narcotic controlled drugs, for use in an industrial health facility shall be purchased or obtained by the medical director from a wholesaler or manufacturer of drugs. In an emergency, prescription drugs, including nonnarcotic controlled drugs, may be purchased or obtained from a licensed pharmacy. Narcotic drugs for use in an industrial health facility shall be purchased or obtained by the medical director from a manufacturer or wholesaler of drugs on an official narcotic order form. The medical director shall register with the internal revenue service and obtain a Class 4 narcotic tax stamp with the address of the industrial health facility.

(3) Administration. Nonprescription drugs may be administered by a physician, a registered nurse, a licensed practical nurse or an individual who has completed successfully the advanced American Red Cross first-aid course or the equivalent in accordance with a written general medical directive from the medical director, or in accordance with a specific written or oral order from a physician for a specific patient. Prescription drugs, including narcotic and other controlled drugs, may be administered by a physician, or by a registered nurse in accordance with a specific oral or written order from a physician for a specific patient. A registered nurse may, in an emergency, administer a prescription drug in accordance with a general written medical directive from the medical director. The physician shall confirm a verbal order in writing on the patient's medical record. Written orders shall be filed in the patient's medical record. Only a physician or registered nurse may administer drugs intramuscularly. Only a physician may administer drugs intravenously.

(4) Dispensing. Drugs may be dispensed by a physician. A drug or drugs dispensed by a registered nurse, when ordered by a physician orally or in writing to dispense a drug or drugs to a specific patient, shall be construed to have been dispensed by the physician. The physician shall confirm a verbal order in writing on the patient's medical record. Written orders shall be filed with the patient's medical record.

(5) Records. (A) Controlled drugs, including narcotics. A record separate from the medical records shall be kept of controlled drugs purchased or received and administered or dispensed. The record shall in each case show the date of receipt, the name and address of the person from whom received and the kind and quantity received. The record shall show the date and time of administration, dispensing or disposal, the name of the person to whom administered, dispensed or disposed, and the kind and quantity of drug, the name of the physician who ordered the drug administered or dispensed and the name of the individual who administered or dispensed the drug. Each such record shall be separately maintained and kept for a period of three years from the date of the transaction recorded. The keeping of a record required by or under federal drug laws containing essentially the same information as is specified above shall constitute compliance with this subsection, provided each record shall, in addition, contain a detailed list of any controlled drugs lost, destroyed or stolen, the kind and quantity of such drugs and the date of the discovery of such loss, destruction or theft. A notation regarding the kind and dosage of each controlled drug administered or dispensed to an employee shall be made in the employee's medical record. This shall be signed and dated by the individual who administered or dispensed the drug. An annual inventory of narcotic drugs shall be prepared in June and filed with the internal revenue service and the Class 4 narcotic tax stamp shall be renewed during June. (B) Prescription drugs other than controlled drugs. A notation regarding the kind and dosage of each prescription drug other than a controlled drug, administered or dispensed to an employee shall be made in the employee's medical record. This shall be signed and dated by the individual who administered or dispensed the drug. (C) Nonprescription drugs. A notation regarding the kind and dosage of each nonprescription drug administered or dispensed to an employee shall be made in the employee's medical record. This notation shall be signed and dated by the individual who administered or dispensed the drug.

(6) Storage. (A) Narcotic drugs. Class A and B narcotic drugs not in excess of twelve taxable items shall be stored in a strong locked nonportable container in a locked medicine cabinet. Keys to the container shall be kept separate from the keys to the cabinet and such keys shall be kept only by a physician or a registered nurse.

Class A and B narcotic drugs in excess of twelve taxable items shall be kept in an approved chest or safe. Class X narcotic drugs shall be stored in the same manner as other prescription drugs. (B) Prescription drugs excluding Class A and B narcotic drugs. Prescription drugs excluding Class A and B narcotic drugs shall be stored in a medicine cabinet. The cabinet shall be locked when neither a physician nor a registered nurse is in attendance in the industrial health facility. Keys to the medicine cabinet shall be kept only by a physician or a registered nurse. (C) Nonprescription drugs. Nonprescription drugs shall be stored in a locked medicine cabinet when no one is in attendance in the industrial health facility.

(7) Labeling. Drugs may be repackaged for stock by a physician. Drugs repackaged for stock by a registered nurse under the direction and supervision of a physician shall be construed to have been repackaged by a physician. The proper label shall be affixed to the container containing repackaged stock drugs. The container in which a drug is dispensed shall contain a label with the name of the patient, name of the drug, strength of the drug, directions for use, name of the prescribing physician, the date of dispensing and the precautions, if any, to be taken. The name of the drug and the strength may be deleted from the label if the label contains a code number or some other device by which the individual dispensing the drug can identify it.

(8) Additional requirements. Additional requirements which the commissioner of health may prescribe regarding safeguarding and handling of drugs in special cases shall be complied with.

(h) **Discontinuation.** The administrator of the industrial health facility shall notify the commissioner of health at least fifteen days prior to discontinuation of operation of an industrial health facility to assure proper disposal of drugs and potentially hazardous equipment and proper disposition of medical records.

(Effective November 9, 1971)

Licensing Outpatient Clinics Operated by Corporations or Municipalities

Sec. 19-13-D45. Definition

Outpatient clinics operated by corporations or municipalities. For the purposes of sections 19-13-D45 to 19-13-D53, inclusive, an outpatient clinic is an organization operated by a municipality or a corporation other than a hospital which provides ambulatory medical or dental care for diagnosis, treatment and care of persons with chronic or acute conditions which do not require overnight care, or medical or dental care to well persons including preventive services and maintenance of health.

(Effective April 4, 1972)

Sec. 19-13-D46. Buildings and equipment

(a) A clinic building shall be of sound construction and shall provide adequate space and equipment for patient interviews, physical examinations and treatment of patients and for service and other areas in accordance with the requirements of the state department of public health.

(b) Clinic buildings and equipment shall meet the requirements of the state fire safety code. Annual application for approval shall be accompanied by a certificate of inspection by the local fire marshal.

(c) Areas in which explosive gases or radioactive materials are used shall provide for adequate protection of patients and personnel.

(d) The clinic buildings and equipment shall be maintained in a good state of repair and shall be kept clean at all times.

(Effective April 4, 1972; amended December 30, 1996)

Sec. 19-13-D47. Governing board, administrator

(a) A clinic shall be managed by a governing board whose duties shall include, as a minimum:

(1) Adoption of bylaws or their equivalent, rules and regulations or their equivalent, including medical or dental staff bylaws, or both;

(2) annual appointment of the medical or dental staff with annual designation of medical or dental director; and

(3) appointment of a clinic administrator, qualified on the basis of training and experience approved by the commissioner of public health.

(b) The administrator, or the equivalent, shall be responsible to the governing board for the management and operation of the clinic and for the employment of personnel. He shall attend meetings of the governing board and meetings of the professional staff.

(c) Personnel shall be employed in sufficient numbers and of adequate qualifications so that the function of the clinic may be performed efficiently.

(Effective April 4, 1972; amended December 30, 1996)

Sec. 19-13-D48. Professional staff

(a) There shall be an organized professional staff of not fewer than three members of the major profession or professions providing care in the clinic; except that, in a family-planning clinic or well-child clinic, the staff may consist of a medical director and one other major profession providing care in the clinic.

(b) The professional staff shall adopt written rules and regulations governing its own activities, subject to approval of the governing board of the clinic. As a minimum these shall include:

(1) Methods of control of privileges granted to members of the medical or dental staff and the responsibilities of the medical or dental director;

(2) method of professional supervision of clinical work;

(3) provision for regular staff meetings;

(4) preparation of adequate case records; and

(5) procedure for recommending appointment to the staff and for hearing complaints regarding the conduct of members, referring the same, with recommendations, to the governing board.

(Effective April 4, 1972; amended December 30, 1996)

Sec. 19-13-D49. Records

(a) There shall be adequate provisions for the retention and storage of medical or dental records with adequate space and equipment and qualified medical record personnel, if necessary. (b) A medical or dental record shall be started for each patient at the time of admission, including proper identifying data. Medical and dental records shall include sufficient information to justify the diagnosis made and warrant the treatment given or services provided. Each entry shall be signed by the person responsible for it. (c) Medical and dental records shall be filed in the clinic in a manner accessible to the professional staff, with proper provision for their confidentiality, and shall be kept for a minimum of five years after discharge of the patient.

(Effective April 4, 1972)

Sec. 19-13-D50. Nursing personnel

Sufficient licensed nursing personnel shall be employed to render the care, treatment or preventive services necessary, including the administration of drugs and biologicals as required by the stated program of the clinic.

(Effective April 4, 1972)

Sec. 19-13-D51. Pharmaceutical

Where pharmaceutical are dispensed other than by a physician there shall be a pharmacy which meets the following requirements: (1) There shall be a competent pharmacist, registered in Connecticut, who shall be responsible to the administrator for all pharmaceutical services in the clinic. (2) The pharmacy shall be operated in compliance with all applicable state and federal drug laws and regulations. (3) The premises shall be kept clean, adequately lighted, and ventilated, and the equipment and facilities necessary for compounding, dispensing, manufacturing, producing or processing of drugs shall be maintained in good order. (4) Drugs used in the clinic shall meet standards established by the United States Pharmacopoeia, The National Formulary or the Federal Food and Drug Administration and shall be stored and kept so as to insure their proper purity and strength. A medical staff pharmacy committee in conference with the pharmacist shall formulate policies to control the administration of toxic or dangerous drugs with specific reference to the duration of the order and the dosage. All applicable statutes and regulations governing the purchase, storage and dispensing of drugs and biologicals shall be in force at all times.

(Effective April 4, 1972)

Sec. 19-13-D52. Maintenance

The management, operation, personnel, equipment, facilities, sanitation and maintenance of the clinic shall be such as reasonably to assure the health, comfort and safety of patients at all times.

(Effective April 4, 1972)

Sec. 19-13-D53. Inspection

Clinics shall be inspected biennially by the state department of public health to test for ongoing compliance with sections 19-13-D45 through 19-13-D54 of the Regulations of Connecticut State Agencies.

(Effective April 4, 1972; amended December 30, 1996)

Sec. 19-13-D54. Abortions

(a) No abortion shall be performed at any stage of pregnancy except by a person licensed to practice medicine and surgery in the State of Connecticut.

(b) All induced abortions will be reported within seven days by the physician performing the procedure to the state commissioner of public health who will maintain such reports in a confidential file and use them only for statistical purposes except in cases involving licensure. Such reports will specify date of abortion, place where performed, age of woman and town and state of residence, approximate duration of pregnancy, method of abortion, and explanation of any complications. The name of the woman will not be given. These records will be destroyed within two years after date of receipt. In addition, a fetal death certificate shall be filed for each fetus born dead which is the result of gestation of not less than twenty weeks, or a live birth certificate shall be filed for each fetus born alive regardless of gestational age, as provided in sections 7-48 and 7-60 of the Connecticut General Statutes. If a live born fetus subsequently dies, a death certificate shall be filed as provided in section 7-62b of the Connecticut General Statutes.

(c) All induced abortions after the second trimester as verified by ultrasound, last menstrual period and pelvic exam, shall be done only in a licensed hospital with a department of obstetrics and gynecology and a department of anesthesiology.

(d) All outpatient clinics operated by corporations or municipalities where abortions are performed shall develop standards to control the quality of medical care provided to women having abortions. These standards shall include but not necessarily be limited to:

- (1) verification of pregnancy and determination of duration of pregnancy;
- (2) pre-operative instruction and counseling;
- (3) operative permission and informed consent;
- (4) pre-operative history and physical examination;
- (5) pre-operative laboratory procedure for blood Rh factor;
- (6) prevention of Rh sensitization;
- (7) examination of the tissue by a pathologist;
- (8) receiving and recovery room facilities;
- (9) a standard operating room;
- (10) post-operative counseling including family planning; and
- (11) a permanent record.

(e) There shall be a mechanism for continuing review to evaluate the quality of records and the quality of clinical work. This review shall include all deaths, complications, infections and such other cases as shall be determined by the chief of the department of obstetrics and gynecology of the hospital or the clinic medical director.

(f) No person shall be required to participate in any phase of an abortion that violates his or her judgment, philosophical, moral or religious beliefs.

(g) If the newborn shows signs of life following an abortion, those measures used to support life in a premature infant shall be employed.

(h) During the third trimester of pregnancy, abortions may be performed only when necessary to preserve the life or health of the expectant mother.

(Effective February 25, 1974; amended December 30, 1996, August 1, 2005)

Sec. 19-13-D55.

Repealed, September 28, 1988.

Sec. 19-13-D55a. Licensure of an out-patient dialysis unit and standards for in-hospital dialysis units

(a) **Definitions.** As used in this section:

(1) "Dialysis Unit" or "Unit" means:

(A) An out-of-hospital out-patient dialysis unit that is a licensed facility which provides services on an out-patient basis to persons requiring dialysis on a short-term basis or for a chronic condition or training for home dialysis; or

(B) An in-hospital dialysis unit that is a special unit of a licensed hospital designed, equipped and staffed to offer dialysis therapy on an out-patient basis, and to provide training for home dialysis and renal transplantation as appropriate.

(2) "Dialysis Treatment" means:

(A) Chronic dialysis given to patients who have reached that stage of kidney impairment that requires dialysis to maintain life; or

(B) Acute dialysis given to patients who require dialysis because of temporary kidney failure.

(3) “Administrator/Director” means an individual employed by and accountable to the unit’s governing body with responsibility for overall management of the unit and compliance with applicable laws and regulations.

(4) “Nurse Manager” means a registered nurse with accountability to the unit administrator/director for the nursing management, provision, coordination and quality of patient care delivered in the unit.

(5) “Charge Nurse” means a registered nurse to whom the nurse manager has delegated accountability for the coordination and supervision of all nursing care activities provided in the dialysis unit for a specified period of time.

(6) “Medical Director” means a physician responsible for supervision and assurance of the quality of the medical, technical and related administrative functions of the dialysis unit.

(7) “Patient Care Staff” means registered nurses, licensed practical nurses and patient care technicians, who provide dialysis treatments to patients.

(8) “Patient Care Technician” means a trained employee in a dialysis unit who may participate in patient care under the direct supervision of a registered nurse.

(9) “Direct Supervision” means supervision of the dialysis treatment continuously in the same room in which the treatment is being performed.

(b) Licensure Procedure.

(1) The Agency of Cognizance. A dialysis unit shall not be constructed, expanded or licensed to operate except upon application for, receipt of approval, and compliance with any limitations and conditions required by the Agency of Cognizance pursuant to Connecticut General Statutes, section 19a-638 and 19a-639, when applicable.

(2) No person shall operate a dialysis unit without a license issued by the Department in accordance with Connecticut General Statutes, Section 19a-491.

(3) Application for Licensure for Out-of-Hospital Out-Patient Dialysis Units.

(A) Application for the grant or renewal of a license to operate an out-of-hospital out-patient dialysis unit shall be made in writing on forms provided by the Department; shall be signed by the person seeking the authority to operate the facility; shall be notarized, and shall include at a minimum the following information:

(i) Evidence of compliance with local zoning ordinances and local building codes upon initial application;

(ii) Local fire marshal’s annual certificate of compliance;

(iii) Statement of ownership and operation;

(iv) Certificate of public liability insurance;

(v) Current organization chart;

(vi) Description of services provided.

(B) Application for license renewal shall be made in accordance with subdivision (A) above and not less than 30 days preceding the date of expiration of the unit’s current license.

(4) Issuance and Renewal of Licensure for Out-of-Hospital Out-Patient Dialysis Units.

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

(B) The license shall not be transferable to any other person, or facility or location.

(C) Each license shall list, on its face, the location and licensed number of hemodialysis stations, the types of treatment services provided, the name of the

licensee, the name under which the unit does business, and the dates of issuance and expiration of said license.

(D) The license shall be posted in a conspicuous place in a room accessible to the public.

(E) The licensee shall notify the Department in writing of any proposed change of ownership, location or services at least ninety days prior to the effective date of such proposed changes.

(5) Surrender of License. The facility shall notify in writing the Department, each patient concerned, the next of kin or legal representative, and any third party payors concerned at least 30 days prior to the voluntary surrender of a 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 current license shall be surrendered, to the Department, within seven days of the termination of operation.

(c) Governing Body

(1) The dialysis unit shall be under the control of a governing body, which shall be responsible for the following:

(A) Oversight of the management and operation of the dialysis unit.

(B) Adoption, and documented annual review of written policies and procedures, governing all aspects of the dialysis unit to include, at a minimum, the following:

(i) Health care and safety of patients;

(ii) The overall quality improvement program for the unit;

(iii) Personnel policies;

(iv) Patient grievance mechanism;

(v) Types of renal dialysis equipment to be utilized;

(vi) Reuse of dialysis devices in accordance with accepted standards of practice;

(vii) Operating hours;

(viii) Methods of selection of patients;

(ix) Patients on transplant status;

(x) Prevention and control of infectious diseases among patients and staff to include appropriate referrals and written notification to the Department of Public Health.

(C) Establishment of written transfer agreements with hospitals in the immediate vicinity for the provision of in-patient services (applicable to out-of-hospital out-patient dialysis units only).

(D) Appointment of a qualified administrator/director.

(E) Appointment of a qualified medical director.

(F) Approval of all appointments made to the medical staff of the dialysis unit.

(G) Determination of the frequency of meetings of the governing body and documentation of such meetings through minutes.

(d) Administrator/Director

(1) The Administrator/Director shall have:

(A) A baccalaureate degree or its equivalent and at least one year of experience in a dialysis unit; or

(B) The qualifications referenced in Section 19-13-D55a (e) (1) or Section 19-13-D55a (g) (2) of these regulations.

(C) Any person currently employed as an administrator/director of a dialysis unit as of September 28, 1988 shall be eligible to continue in the unit of employment without restriction.

(2) The administrator/director shall be responsible for the overall management of the unit and shall have the following responsibilities:

(A) Implementation of the policies and procedures which have been adopted by the governing body.

(B) Maintenance of procedure manuals, which are made available to all personnel, to include documented annual review with revisions made as appropriate.

(C) Ensuring compliance with applicable local, state, and federal regulations and laws.

(3) The Department shall be notified in writing, within five (5) business days of any change of administrator/director of the dialysis unit.

(e) **Medical Director.**

(1) The medical director shall be a physician licensed to practice medicine in Connecticut and who is board eligible or certified in nephrology by a professional board and who has at least 12 months experience in the care of patients in dialysis facilities.

(2) Any person currently serving as a medical director of a dialysis unit as of September 28, 1988 shall be eligible to continue in the dialysis unit of employment without restrictions.

(3) The medical director shall:

(A) Enforce the unit's policies and procedures governing medical care;

(B) Ensure that quality patient care is provided in the dialysis unit;

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

(D) Recommend to the governing body the approval or denial of applications for membership on the medical staff;

(E) Designate in writing a physician licensed to practice medicine in Connecticut and who is board eligible or certified in nephrology to act in his or her absence.

(4) The Department shall be notified in writing, within five (5) business days of any change of medical director of the dialysis unit.

(f) **Medical Staff.**

(1) Each facility shall have an active organized medical staff.

(2) Medical staff of a dialysis unit shall be physicians licensed in the State of Connecticut who have completed or are in the process of completing special education and training programs, which shall include renal physiology and pathology.

(3) The active organized medical staff shall adopt written policies and procedures governing the medical care of the dialysis unit's patients. Such policies and procedures shall be approved by the medical director and the governing body. The policies and procedures shall include, at a minimum:

(A) Acceptable standards of practice for the medical staff;

(B) Participation in the medical components of the unit's quality improvement program.

(C) 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 who is board eligible or certified in nephrology on the facility's active organized medical staff is temporarily appointed to serve in that capacity.

(D) Protocols for services, if any, which may be provided by non-physician health professionals such as physician's assistants or advanced practice registered nurses.

(4) Members shall meet at least quarterly. Minutes shall be maintained for all such meetings. The regular business of the medical staff meetings shall include, at a minimum, analysis of and recommended actions concerning the medically related components of the unit's quality improvement program, including but not limited to adverse incidents and trends in patient-related dialysis parameters, including outcomes.

(g) Nurse Manager.

(1) The administrator/director shall appoint as nurse manager, a registered nurse licensed in the State of Connecticut.

(2) The nurse manager shall have special education, training and experience in dialysis techniques, 12 months of experience in clinical nursing and an additional 6 months of experience in nursing care of patients with permanent kidney failure who are receiving dialysis treatments.

(3) The nurse manager is responsible for the supervision, provision and quality of nursing care to include the coordination of all nursing activities in the dialysis unit. The nurse manager shall ensure that quality nursing care is provided in the unit.

(4) A charge nurse shall be designated by the nurse manager as responsible for the dialysis unit's nursing activities during the nurse manager's absences.

(5) In addition to the nurse manager, who shall not be counted in the dialysis unit's staffing pattern, there shall be sufficient numbers of licensed nurses and additional personnel to meet the patient care needs of the unit. At all times, at least fifty per cent (50%) of the unit's patient care staff shall be licensed nurses. There shall be a registered nurse on duty at all times when the unit is in operation.

(A) The nurse manager shall implement a patient acuity system which is used to determine the appropriate numbers and types of patient care staff to meet predicted needs of patients on each shift. The acuity system used shall include:

(i) Categorization of patient needs performed on at least a monthly basis;

(ii) A quantitative mechanism to link patient needs to an appropriate number of patient care staff for each shift;

(iii) A mechanism to differentiate which patient needs are appropriate for different levels of patient care staff;

(iv) A plan for management of staffing emergencies affecting patient care;

(v) Documentation of the patient acuity system maintained in the unit for one year.

(B) The nurse manager shall develop a methodology to periodically determine if the acuity system and unit staffing remain appropriate to the patient population being served.

(C) The nurse manager shall ensure that there is sufficient supervision to provide continuous monitoring of individual dialysis treatments.

(h) Nursing Staff.

(1) Qualified nursing staff of a dialysis unit shall consist of registered nurses and practical nurses who are licensed in the State of Connecticut. A training program, which shall be provided by the dialysis unit of employment prior to the employee functioning in the position, shall include, at a minimum, the following:

(A) Instruction in anatomy and physiology, fluid and electrolyte balance, principles related to dialysis systems and devices, renal drug therapy, complications of dialysis therapy, emergency medical procedures, asepsis and infection control, dietary management and concepts of chronic end stage renal dialysis rehabilitation and patient education.

(B) Documented validation of competency in both theory and practice.

(2) Provisions shall be made for periodic and systematic evaluation of performance.

(3) All nursing staff shall participate in continuing education programs on an annual basis.

(4) Registered nurse staff shall be responsible for all patient assessments, including initial and discharge assessments.

(i) Additional Personnel.

(1) Patient Care Technicians.

(A) Patient care technicians shall comprise no more than 50% of staff providing direct care in the dialysis unit, with at least 50% of caregiver staff being licensed nurses.

(B) Patient care technicians may collect baseline objective patient care data; initiate, monitor and terminate dialysis treatments, and contribute information for the patient's ongoing plan of care.

(C) A written patient care technician training program, Approved by the unit's governing body, shall be developed to meet the needs of the individual unit. Training programs, which shall be provided by the unit of employment prior to the employee functioning in the position, shall include, at a minimum, the following:

(i) An introduction to dialysis, including principles of dialysis; care of the patient with kidney failure; dialysis procedures, including initiation, monitoring and termination of dialysis treatment; possible complications of dialysis; water treatment; infection control; and safety and dialyzer reprocessing, if applicable.

(D) A registered nurse shall be responsible for coordination of the clinical training of the patient care technician and shall assure that each patient care technician has completed the training program and has demonstrated competency in all clinical and theoretical areas.

(E) Records shall be kept to verify the participation and performance of each trainee in each phase of the training program. The satisfactory completion of the training program shall be attested to on each trainee's record by a registered nurse.

(F) Each patient care technician shall have an annual evaluation of performance. This evaluation shall be written and maintained for a minimum of three years.

(G) Each patient care technician shall participate in continuing education programs on an annual basis.

(H) Minimum qualifications for patient care technicians shall be a high school diploma.

(2) Other technical staff.

(A) Other technical staff shall be appropriately trained and tested to perform the assigned tasks and functions described in the dialysis unit's job description. This training program shall be provided by the dialysis unit of employment and each component shall be satisfactorily completed prior to the employee performing the component independently. Verification of competency shall be in writing.

(B) Other technical staff shall function under the supervision of the nurse manager.

(C) Other technical staff may not initiate, monitor or terminate dialysis treatments.

(3) Social Worker.

(A) The administrator/director shall appoint a qualified social worker.

(B) A qualified social worker shall be licensed pursuant to section 20-195m of the general statutes of Connecticut.

(C) Social work staff shall be employed in sufficient numbers to meet the needs of the patients.

(D) The social work staff shall assess and monitor each patient's adjustment to the social and emotional aspects of the patient's illness and treatment, provide casework or groupwork for patients and families as needed, participate in team reviews of patients' progress and make recommendations regarding treatment based on the patient's current psychosocial needs, provide direction for financial assistance, identify community resources and assist patients and families in utilizing them.

(4) Dietitian.

(A) The administrator/director shall appoint a qualified dietitian who shall be registered by the American Dietetic Association and who has at least one year of experience in clinical nutrition.

(B) The qualified dietitian shall be responsible for:

- (i) A comprehensive assessment of patients' nutritional and dietetic needs;
- (ii) Recommending medical nutritional therapy;
- (iii) Counseling patients and significant others regarding nutritional and dietetic needs;
- (iv) Monitoring patient responses, both physiological and psychosocial, to medical nutritional therapy.

(C) Dietitian staff shall be employed in sufficient numbers to meet the needs of the patients.

(5) Medical Records Practitioner.

(A) The administrator/director shall appoint a qualified medical records practitioner who:

(i) Has graduated from a program for medical record administrators accredited by the Council on Medical Education of the American Medical Association and the American Medical Record Association, and is certified or is eligible for certification as a registered record administrator (RRA) by the American Medical Record Association; or

(ii) Has graduated from a program for medical record technicians approved jointly by the Council on Medical Record Education of the American Medical Association and the American Medical Record Association and is certified or is eligible for certification as an accredited record technician (ART) by the American Medical Record Association; or

(iii) Has successfully completed and received a passing grade in the American Medical Record Association's Correspondence Course for Medical Record Personnel approved by the Accrediting Commission of the National Home Study Council, and is certified or is eligible for certification as an accredited record technician by the American Medical Record Association; or

(iv) If the medical records practitioner cannot satisfy the above qualifications, the provisions of this section may be met if such person functions with consultation from a person who qualifies under paragraph(5) (A) (i) (ii) (iii).

(B) The medical records practitioner shall be responsible for the maintenance of medical records in accordance with accepted standards of practice and for quarterly audits of records.

(6) All housekeeping and cleaning staff shall receive training to ensure that technical procedures used in cleaning and housekeeping are implemented to protect the health and safety of patients, staff and the public.

(7) Other staff as deemed necessary for the care of the patient. Such staff will function under the supervision of the appropriate qualified professional.

(j) **Clinical Records.**

(1) There shall be adequate provision for the retention and storage of all clinical records which shall ensure the safety of such records and the confidentiality of the information contained therein.

(2) Adequate space and equipment shall be provided for record keeping, and the records shall be maintained in a secure manner so as to protect their confidentiality and integrity.

(3) A clinical record shall be started for each patient at the time of admission to the unit to include all identifying data. Each patient's record shall contain sufficient

information to justify the diagnosis and warrant the treatment given or services provided. A patient care plan including specific interventions to meet all identified patient needs shall be included. Each entry in the record shall be signed by the person responsible for it immediately after the service or treatment is rendered.

(4) All records shall be maintained in an out-of-hospital out-patient dialysis unit for a minimum of five years following the discharge of the patient. When records are archived off-site or stored electronically, provisions shall be made for retrieval and maintenance of confidentiality.

(5) Entries shall be made in the clinical record by all disciplines at least quarterly and at the time of any changes in the patient's condition or treatment.

(k) Pharmaceutical Services.

(1) The dialysis unit shall ensure the availability of pharmaceutical services, where indicated, to meet the needs of the patient.

(2) The pharmaceutical services shall be under the direction of a licensed pharmacist who shall be directly responsible to the administrator/director for:

(A) Supervision of the pharmaceutical services to assure conformance with accepted standards of practice, unit policies and all applicable state and federal laws.

(B) Development and implementation of current written policies and procedures that govern the procurement, storage, preparation, distribution, disposal, control and recording of drugs and biologicals.

(C) Inspection of all drug preparation and storage areas (including emergency drugs) at suitable intervals to ensure that:

(i) Drugs and biologicals are dispensed, packaged and labeled in accordance with accepted standards of practice and all applicable state and federal laws.

(ii) Drugs and biologicals are stored under proper conditions of sanitation, security, segregation and environmental control.

(iii) Drugs and biologicals which are out-dated, deteriorated, subjected to a drug recall, improperly labeled or discontinued are disposed of in accordance with approved procedures.

(iv) Emergency drugs are in adequate supply.

(v) Complete and accurate records are maintained for the receipt and disposition of controlled substances.

(3) The licensed pharmacist shall be responsible for:

(A) Establishment of quality control specifications for the procurement of drugs and biologicals used in the treatment of patients.

(B) Monitoring the drug therapy of patients for drug interactions, as appropriate.

(C) Participation, as appropriate, in inservice educational programs for the professional staff pertinent to drug therapy.

(D) Participation, as appropriate, in patient care conferences.

(E) Participation, as appropriate, in drug related patient and family education and counseling.

(4) There shall be current, written policies and procedures, approved by the medical staff, that govern the safe prescribing and administration of drugs and the proper recording of medication administration in the unit.

(l) General.

(1) For each position in the dialysis unit, there shall be a job description identifying required qualifications, training and/or past experience and the specific duties of the position.

(2) There shall be a program of continuing staff education provided in order to maintain and improve knowledge and skills.

(3) There shall be ancillary and functional dialysis machines readily available in the facility.

(4) The facility shall provide any special dialysate formulas (non-routine formulas of acetate) required by patients.

(5) On each dialysis unit or in close proximity there shall be maintained, at a minimum, emergency equipment and drugs for resuscitation and defibrillation.

(6) The management, operation, personnel, equipment, facilities, sanitation and maintenance of the dialysis unit, to include the care and services rendered within the dialysis unit, shall be such as to reasonably ensure the health, comfort and safety of patients, staff and the public at all times.

(7) Written fire and disaster plans shall be formulated and posted in a conspicuous location.

(8) If the unit provides self-dialysis training, the following support services shall be provided:

(A) Initial and periodic assessment by the appropriate professionals of the patient's home adaptation, including visits to the home, based on the patient's needs, and arrangements for monthly follow-up visits at the dialysis unit. The patient care plan shall include a schedule of assessments.

(B) Consultation with a qualified social worker and dietitian.

(C) Installation and maintenance of equipment.

(D) Ordering of supplies on an ongoing basis.

(E) Testing and appropriate treatment of water for home hemodialysis patients.

(m) **Physical Plant Standards.**

(1) General Provisions.

(A) All plans and specifications for new construction or alterations shall be submitted to the State Department of Public Health, the local Fire Marshal and the local building inspector for approval before construction is undertaken.

(B) Any facility licensed after the effective date of these regulations shall conform with the construction requirements described this section. Any facility licensed prior to the effective date of these regulations shall comply with the construction requirements in effect at the time of licensure. However, if the Commissioner or the Commissioner's designee determines 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.

(C) Waiver.

(i) The Commissioner or his/her designee, in accordance with the general purposes and intent of these regulations, may waive provisions of the Physical Plant Standards 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.

(ii) 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.

(iii) In consideration of any application for waiver, the Commissioner or his/her designee may consider the following:

- (a) The maximum patient capacity;
- (b) The impact of a waiver on care provided;
- (c) Alternative policies or procedures proposed.

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

(v) 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.

(2) Site.

(A) The site or location of a new dialysis unit shall be approved by the State Department of Public Health.

(B) No facility shall be constructed or converted to this use without city water and sanitary sewers.

(C) Adequate off street parking stalls shall be provided at the ratio of one for each patient station.

(3) Code.

(A) All new dialysis units shall comply with the State of Connecticut Fire Safety Code and Supplements and the State Basic Building Code and Supplements and local zoning ordinances. Only the most current and most stringent code or regulation shall be used.

(B) Facilities shall be usable by and accessible to persons with disabilities.

(C) An annual certificate from the local fire marshal shall be submitted with the application for licensure to the State Department of Public Health.

(4) Administration. The following shall be provided:

(A) Entrance. A grade level or ramp entrance way. In multi-story structures where the unit is above street level there must be ready access to an elevator which can accommodate a stretcher and attendant.

(B) Waiting room. Two toilet areas and a public telephone, all equipped for use by persons with disabilities, and seating accommodations for waiting periods shall be available or accessible to the dialysis unit. Provisions shall be made for the protection and security of patients' personal belongings.

(C) General or Individual Offices. The following shall be provided:

(i) Storage for medical records and office space for administrative and professional staffs.

(ii) Combination physician's office and examination room.

(iii) Office space for Dietitians and Social Workers which is available on or accessible to the dialysis unit.

(5) Patient Treatment Area. The following shall be provided in a dialysis unit:

(A) Each patient bed shall be located to provide clearance of three feet (3') on each side and front.

(B) The lounge chair shall be located to permit a clearance of three feet (3') on each side and front.

(C) The unit shall be designed to provide privacy for each patient by the use of cubicle curtains, or by separate cubicles.

(D) An isolation room of a minimum of one-hundred square feet (100') shall be provided, with a toilet room, and an entry vestibule or outer room, containing sink, counter space, and storage space. The lavatory shall be located within the isolation

room. The isolation room shall be a part of the unit. A separate entrance from inside the unit to the isolation room shall also be provided.

(E) Handwashing facilities shall be convenient to the treatment area.

(F) Individually controlled reading lights shall be provided for each patient station.

(G) A private treatment room of at least one hundred twenty-five square feet (125') shall be provided for patients who are being trained to use dialysis equipment at home.

(6) Nursing Unit. The following shall be provided in a dialysis unit:

(A) A nurses' station, which has direct visual observation of all patients.

(B) Medication preparation area - provision shall be made for an area to prepare medications. This may be a medication room of not less than forty-five square feet or a self-contained mobile medication cabinet. The medication preparation area shall be equipped with locked storage and non-portable steel storage for controlled substances. If a mobile medication cabinet is not stored within a locked area it may be located in close proximity to the nurses' station provided it is secured with a docking mechanism. All mobile medication cabinets shall be closed and locked when not in current use.

(C) Clean workroom, which shall contain a work counter, handwashing sink, and enclosed storage facilities for clean and sterile supply materials.

Minimum of fifty square feet (50').

(D) Soiled workroom, which shall contain a flush rim sink, handwashing sink, work counter, storage cabinets, waste receptacle and soiled linen receptacle. Minimum of one-hundred square feet (100'). Out-of-hospital out-patient units shall also have bedpan flushing devices that sterilize bedpans if disposable bedpans are not used.

(E) Nourishment station is optional, but if provided, shall contain a handwashing sink, refrigerator, and a storage cabinet. The station shall not be located within the treatment area.

(F) Clean linen storage area or space for a unit linen cart with cover, if linen is provided.

(G) An environmental services closet shall be provided adjacent to and for the exclusive use of the unit. The closet shall contain a floor receptor or service sink and storage space for housekeeping supplies and equipment.

(H) In those units in which a piped in oxygen system is not provided, a separate storage closet shall be provided for the storage of oxygen cylinders.

(I) Supply areas of twenty square feet (20') of floor area per patient station or supply carts shall be provided.

(J) Central Delivery Systems. Each facility using a central delivery system shall provide either on the premises, a Central Batch Mixing Room, or through written arrangements, a delivery system for solutions used for the treatment of patients. If used, a Central Batch Mixing Room shall contain mixing, storage and distribution equipment, a sink, storage space and holding tanks. For facilities using bulk or premixed solutions, storage and distribution spaces shall be provided.

(K) Equipment maintenance room of not less than one-hundred and fifty square feet and equipped with a hand wash sink and a deep service sink. There shall be at least one reverse osmosis (RO) supply available for each fifteen stations up to a maximum of two.

(L) An equipment storage room for the storage of clean equipment available for patient use.

(M) Dialyzer reuse room. If dialyzers are reused, a reprocessing room is required, sized to perform the functions required and to include one-way flow of materials from soiled to clean with provisions for refrigeration (if dialyzers are stored prior to reprocessing), decontamination/cleaning areas, sinks, processors, packing area, dialyzer storage cabinet(s), and a computer and label printer, if used.

(7) Staff Facilities. Staff toilet and lockers shall be provided within the unit. All units shall provide a staff locker room measuring ten square feet per patient station, or sixty square feet whichever is more, provided however that the staff locker room need not exceed a size of one-hundred fifty square feet.

(A) A separate staff dining/lounge shall be provided in out-of-hospital units.

(8) Details of Construction and Electrical Requirements. The following shall be provided:

(A) Corridors shall not be less than five feet wide in an out-of-hospital out-patient unit.

(B) Acoustic treated ceilings shall be provided in corridors, treatment areas, nurses' stations, work areas and waiting area.

(C) An intercom and emergency call signaling system shall be provided between the isolation room, the home training room, patient toilet rooms, nurses' station and the staff dining/lounge area.

(D) Ceiling heights in patient treatment areas shall not be less than eight feet and seven feet, eight inches in all other rooms.

(E) Wall surface finishes shall be washable and moisture resistant.

(F) The minimum width of doors to patient treatment areas shall be three feet, ten inches, two feet, six inches for doors for staff use, and three feet eight inches elsewhere.

(G) All sinks or lavatories in the clinical area shall be provided with any device other than hand controls, soap, paper towels, and dispensers.

(H) Wall bases in treatment areas, soiled workrooms, equipment maintenance room, environmental services closet and other areas which are frequently subject to wet cleaning methods shall be made integral with the floor.

(I) Cubicle curtains and draperies shall be non-combustible or flame retardant.

(J) No walls shall block the view from the nurses' station to the patient area in a given treatment area.

(K) Hospital type hardware shall be provided on doors to clean work rooms, soiled workrooms and the isolation room.

(L) All plumbing lines, electrical conduit, and HVAC systems shall be enclosed.

(M) All materials, including equipment, conductors, controls and signaling devices shall be installed to provide a complete electrical system.

(N) All electrical, mechanical, or piping installations and systems shall be tested prior to initial licensure. The records of tests performed shall be maintained on the premises for at least three years.

(O) A written preventative maintenance program shall be developed and implemented. All records of the program shall be maintained for a three year period.

(9) Mechanical Systems. The following shall be provided:

(A) Plumbing.

(i) Plumbing for the unit shall be designed to provide a minimum water pressure adequate to the needs of the equipment used with waste lines serving the dialysis equipment designed to prevent backflow and necessary check valves and shutoff valves appropriately located in the plumbing system.

(ii) Backflow preventers (vacuum breakers) shall be installed on hose bibbs, janitor's sinks, bedpan flushing attachments, clinical sinks, and all other attachments to which hose or tubing can be attached.

(iii) If a centralized dialysate delivery system is utilized, each distribution line shall be clearly labeled and color-coded to identify its contents.

(B) Electrical Service.

(i) There shall be a minimum of two duplex receptacles on each side of a patient bed or lounge chair. Additional receptacles may be located where convenient for use.

(ii) Receptacles shall be located at least thirty-six inches (36") above the floor and be of "hospital grade" construction.

(C) Emergency Electrical Service.

(i) General. To provide electricity during an interruption of the normal electric supply that could effect the nursing care, treatment, or safety of the occupants, an emergency source of electricity shall be provided and connected to all circuits for lighting and power.

(ii) Source. The source of this emergency electrical service shall be as follows: An emergency electrical generating set, including prime mover and generator, equipped with an automatic transfer switch (which will transfer within ten seconds), shall be located on the premises and shall be reserved exclusively for supplying the emergency electrical system. The emergency generator set shall be of sufficient kilowatt capacity to supply all lighting and power load demands of the emergency system. The power factor rating of the generator shall not be less than eighty percent.

(D) Emergency Electrical Connections. Emergency electrical services shall be provided to circuits as follows:

(i) Lighting.

(a) All task lighting, exitways, exit signs, exit directional signs, exit doorways, stairways, corridors, lobby, dialysis distribution systems and related equipment, and, if provided, the water treatment system.

(b) Patient treatment rooms/cubicles, nursing station, medication preparation area, clean workroom, soiled workroom, equipment storage and waiting room.

(c) Generator set location and switch gear location.

(ii) Equipment.

(a) A minimum of one duplex receptacle on each side of patient bed/chair, or line isolation monitor panels connected to a dedicated circuit of a minimum of twenty (20) amperes.

(b) One duplex receptacle in the equipment maintenance room.

(c) Corridor receptacles in the patient treatment area.

(d) Essential refrigerators.

(e) Telephone equipment, nurses' call and intercom systems which depend upon electrical power supplied by facility.

(f) Central batch delivery, water treatment, and related systems and equipment.

(g) Dialyzer reuse equipment.

(h) Ventilation equipment.

(1) Environmental Sanitation.

(A) Space and facilities, either on site or through contractual arrangements, shall be provided for the sanitary storage and disposal of contaminated waste.

(B) The water supply shall be tested at least twice annually by a state approved laboratory as to sanitary, chemical, physical and bacteriological composition. Levels will be maintained in accordance with written unit policies. A record of test results shall be maintained in the unit for a period of three years.

(12) Laboratory. Any dialysis unit which carries out laboratory testing, other than that allowed by a clinical laboratory improvement act of 1988 certificate of waiver, within the unit itself shall establish a separate room properly labeled as a laboratory. This room shall be capable of being closed off from the rest of the unit by a suitable door. This laboratory shall contain a work counter, storage cabinet, sink and other appropriate equipment and supplies.

(13) Ventilation System Details. The following shall be provided:

(A) All air supply and air exhaust systems shall be mechanically operated. All fans serving the exhaust system shall be located at the discharge end of the system. The ventilation rates shown in Table I shall be minimum rates and shall not be considered as precluding the use of higher ventilation rates.

(B) Duct linings shall not be used in HVAC systems.

(C) All central ventilation or air conditioning systems shall be equipped with filters having efficiencies no less than 80 percent.

(D) Corridors shall not be used to supply air to any room.

(E) HVAC temperature and humidity shall provide the following: temperature 70-76°F; relative humidity 30% minimum - 50% maximum.

TABLE I - GENERAL PRESSURE RELATIONSHIPS AND VENTILATION OF CERTAIN DIALYSIS AREAS

<i>Area Designation</i>	<i>Pressure Relationship to Adjacent Areas</i>	<i>Minimum of Changes of Outdoor Air per Hour Supplied to Room</i>	<i>Minimum Total Air Changes per Hour Supplied to Room</i>	<i>All Air Exhausted Directly to Outdoors</i>
Patient Treatment Area	P	2	6	Yes
Office(s)	E	Optional	2	Yes
Examination and Treatment Room	V	Optional	6	Optional
Waiting Room	N	2	6	Optional
Medication Room	P	Optional	6	Optional
Isolation Room	N	2	2	Yes
Isolation Room Alcove or Anteroom	N	2	10	Yes
Soiled Workroom	N	Optional	10	Yes
Clean Workroom	P	Optional	4	Optional
Equipment Maintenance Room	P	Optional	6	Yes
Toilet Rooms	N	Optional	10	Yes
Equipment Storage Room	V	Optional	2	Optional
Environmental Services Closet	N	Optional		Yes
Sterilizer Equipment Room	N	Optional	10	Yes
Laboratory	N	Optional	6	Yes
Soiled Linen	N	Optional	10	Yes
Clean Linen Storage	V	Optional	2	Optional
Dialyzer Reuse Room	N	2	12	Yes
Central Batch Mixing Room	N	2	12	Yes

P = Positive N = Negative E = Equal V = Varying
 (Effective September 28, 1988; amended October 2, 1997)

Licensing of Out-Patient Surgical Facilities Operated by Corporations

Sec. 19-13-D56. Licensing of out-patient surgical facilities operated by corporations

(a) **Definition.** (1) For the purpose of section 19-13-D56, an out-patient surgical facility is defined as operated by a corporation other than a hospital which provides ambulatory surgical care in addition to the provision of medical care for diagnosis and treatment of persons with acute or chronic conditions or to the provision of surgical care to well persons.

(2) Ambulatory surgical care is defined as surgical care not requiring overnight stay but requiring a medical environment exceeding that normally found in a physician's office. This medical environment may include any or all of the following:

(A) The pathological process for which the operation is to be performed shall be localized and not conducive to systemic disturbance.

(B) The patient shall not, in the opinion of the attending physician, have other significant physiological, biochemical or psychiatric disturbance which might be worsened by the operation.

(C) The preoperative work-up to be done following admission shall not be such as to extend the admission beyond the normal period of clinic operation during one day.

(D) The postoperative recovery period anticipated shall not require skilled medical or nursing care such as to extend the admission beyond the normal period of clinic operation during one day.

(E) Anesthesia requirement, which may render the patient unconscious and unable to walk, but which will not prohibit discharge during the normal period of clinic operation during the day on which the operation is performed.

(b) **Physical Standards.** A. Plans and specifications for new construction or alterations shall be submitted to the state department of health for review and approval before construction is undertaken.

B. The commissioner of health has issued the following minimum requirements concerning the physical standards which will be the basis for review in the state department of health.

(1) Code. (a) Every building where, on or after the effective date of these regulations, is constructed or converted for use, in whole or in part, as an out-patient surgical center shall comply with the requirements of the Basic Building Code, as prepared by the Public Works Department, State of Connecticut; except as such matters are otherwise provided for in a local municipal charter, or statutes, or in the rules and regulations authorized for promulgation under the provisions of the Basic Building Code.

(b) In addition to the State of Connecticut Basic Building Code, all out-patient surgical facilities shall comply with the requirements of the following codes and standards:

- (1) State of Connecticut Fire Safety Code
- (2) NFPA—101 Life Safety Code
- (3) NFPA—76A Essential Electrical Systems for Health Care Facilities
- (4) NFPA—56A Inhalation Anesthetics
- (5) NFPA—56F Nonflammable Medical Gases
- (6) NFPA—56G Inhalation Anesthetics in Ambulatory Care Facilities

(7) For reference purposes only—NFPA—76B-M Electricity in Patient Care Facilities

(8) The State of Connecticut labor laws, local fire safety codes and zoning ordinances. Only the most current code or standard shall be used.

(c) Facilities shall be available and accessible to the physically handicapped and designed in accordance with ANSI standards.

(d) An annual certificate from the local fire marshal that precautionary measures meet his approval shall be submitted with the annual application for licensure to the state department of health.

(2) Site. The site or location of a new surgical outpatient center shall be approved by the state department of health.

(3) Size and Design. (a) The extent (number and types) of the diagnostic, clinical and administrative facilities to be provided will be determined by the services contemplated and estimated patient load.

(b) Prime consideration shall be given to patient traffic from the patient parking area to out-patient admissions and through the surgical department to discharge offices and to covered areas for patient pick-up.

(4) Privacy for Patient. The design of the facility shall provide for the privacy and dignity of the patient during interview, examination and treatment.

(5) Maintenance of Systems and Equipment. All electrical gas, fire and alarm systems and equipment shall be tested to standards initially prior to the placing in service and tested periodically thereafter. Permanent records shall be maintained.

C. Administrative Provisions. The following shall be provided: (1) Entrance. At grade level or ramped and in multi-story structures where the unit is above street level, ready access to an elevator.

(2) Waiting Room. Public toilet facilities, drinking fountain, public telephone, and seating accommodations for long waiting periods shall be provided on the premises.

(3) General or Individual Offices. For medical records and administrative and professional staffs.

(4) Interview space(s) for private interviews relating to social services, credit and admissions.

(5) Special Storage. For employees', patients' personal effects.

D. Clinical Facilities. The following shall be provided: (1) General Purpose Examination Room(s). For medical, obstetrical and similar examinations. Shall have a minimum floor area of eighty (80) square feet each, excluding such spaces as vestibule, toilet, closet and work counter (whether fixed or movable). A lavatory or sink equipped for handwashing and a counter or shelf space for writing shall be provided.

(2) Treatment Room(s) for Minor Surgical Procedures and Cast Procedures. Shall have a minimum floor area of one hundred-twenty (120) square feet each, excluding such spaces as vestibule, toilet, closet, and work counter (whether fixed or movable). The minimum room dimension shall be ten feet. A lavatory or sink equipped for handwashing and a counter or shelf space for writing shall be provided.

(3) Outpatient surgery change areas. A separate area shall be provided where out-patients change from street clothing into hospital gowns and are prepared for surgery. This would include a waiting room, lockers, toilets, clothing change or gowning area, and space for the administration of medications.

(4) Laboratory. Any out-patient surgical center which carries out laboratory testing within the unit itself shall establish a separate room properly labeled as a laboratory. This room shall be capable of being closed off from the rest of the unit by a suitable

door. This laboratory shall contain a work counter, storage cabinets and sink and other appropriate equipment and supplies.

(5) Operating Room(s). Each operating room shall have a minimum clear area of two hundred fifty (250) square feet exclusive of fixed and movable cabinets and shelves. Additional clear area may be required by the program to accommodate special functions in one or more of these rooms. Provide an emergency communication system connecting with the surgical suite control station. Provide at least one X-ray film illuminator in each room, oxygen and vacuum.

(6) Recovery Room(s). Room(s) for post-anesthesia recovery for outpatient surgical patients shall be provided and shall contain handwashing facilities, charting facilities, clinical sink with oxygen and vacuum available for each patient.

E. Surgical Service Areas. The following services shall be provided: (1) Control station located to permit visual surveillance of all traffic which enters the operating suite.

(2) Supervisor's office or station (may be shared with the control station.)

(3) Sterilizing facility(ies) with high speed autoclave(s) conveniently located to serve all operating rooms. When the program indicates that adequate provisions have been made for replacement of sterile instruments during surgery, sterilizing facilities in the surgical suite will not be required.

(4) Scrub facilities. Two scrub stations shall be provided near entrance to each operating room; however, two scrub stations may serve two operating rooms if the scrub stations are located adjacent to the entrance of each operating room. Provide viewing panels with wired glass to permit observation of the operating room from the scrub area.

(5) Soiled workroom for the exclusive use of the surgical suite staff. The soiled workroom shall contain a clinical sink or equivalent flushing type fixture, work counter, sink equipped for handwashing, waste receptacle, and linen receptacle.

(6) Clean workroom. A clean workroom is required when clean materials are assembled within the surgical suite prior to use. A clean workroom shall contain a work counter, sink equipped for handwashing, and space for clean and sterile supplies.

(7) Anesthesia Storage Facilities. A separate room shall be provided for the storage of flammable gases (in accordance with the requirements detailed in NFPA 56A) if such gases are used.

(8) Anesthesia workroom for cleaning, testing and storing anesthesia equipment. It shall contain a work counter and sink.

(9) Medical gas storage. Space for reserve storage of nitrous oxide and oxygen cylinders shall be provided and constructed of one hour fire resistive construction and in accordance with NFPA 56A and 56F.

(10) Equipment storage room(s) for equipment and supplies used in surgical suite.

(11) Staff clothing change area. Appropriate areas shall be provided for male and female personnel (orderlies, technicians, nurses and doctors) working within the surgical suite. The areas shall contain lockers, showers, toilets, lavatories equipped for handwashing, and space for donning scrub suits and boots. These areas shall be arranged to provide a one-way traffic pattern so that personnel entering from outside the surgical suite can change, shower, gown, and move directly into the surgical suite. Space for removal of scrub suits and boots shall be designed so that personnel using it will avoid physical contact with clean personnel.

(12) Lounge and toilet facilities for surgical staff.

(13) Janitors' closet. A closet containing a floor receptor or service sink and storage space for housekeeping supplies and equipment shall be provided exclusively for the surgical suite.

(14) Doctors' Dictation. This space should be private and adequate in size for the total number of doctors who may be dictating at the same time. It should be located adjacent to but not inside the nurses' station, lounge or doctors' dressing area.

F. Supporting Services. (1) Janitors' Closet(s). This room shall contain a floor receptor or service sink and storage for housekeeping supplies and equipment.

(2) Stretcher Storage Area. This area shall be out of direct line of traffic.

(3) Employees' Facilities. Locker rooms, lounges, toilets, or shower facilities, as required, shall be provided to accommodate the needs of all personnel.

(4) Nourishment Rooms. Facilities and space should be provided for preparation of light nourishment, and refrigeration of juices. An ice machine is desirable. Hand-washing facilities must be provided in the room; should be located near the recovery suite.

(5) General Storage Facilities. For office supplies, sterile supplies, pharmaceutical supplies, splints and other orthopedic supplies, and housekeeping supplies and equipment.

G. Details and Finishes. All details and finishes shall meet the following requirements:

(1) Details. (a) Minimum public corridor width shall be five feet, zero inches (5'-0"). Patient transfer corridors shall be eight feet, zero inches (8'-0") wide.

(b) Each building shall have at least two exits remote from each other. Other details relating to exits and fire safety shall be in accordance with the State Fire Safety Code.

(c) The minimum width of doors for patient access to examination and treatment rooms shall be three feet, zero inches (3'-0"); operating and recovery room doors shall be three feet, 10 inches (3'-10") wide and seven feet, zero inches (7'-0") high.

(d) Doors on all openings between corridors and rooms or spaces subject to occupancy, except elevator doors, shall be swing type.

(e) The location and arrangement of handwashing facilities shall permit their proper use and operation. Particular care shall be given to the clearances required for blade-type operating handles.

(f) Paper towel dispensers and soap dispensers shall be provided at all handwashing fixtures.

(g) Radiation protection requirements of X-ray and gamma ray installations shall conform with NCRP Reports Nos. 33 and 34. Provisions shall be made for testing the completed installation before use.

(h) All handwashing sinks used by medical and nursing staff shall be trimmed with valves which can be operated without the hands.

(i) If flammable gases are used, compliance with all requirements of NFPA 56A Inhalation Anesthetics is required for the installation of conductive flooring, electrical systems, ventilation requirements and maintenance.

(j) Ceiling heights shall not be less than nine feet, six inches (9'-6") in operating rooms, and eight feet, zero inches (8'-0") in all other rooms and corridors.

H. Finishes. (1) Flame spread and smoke developed ratings of finishes shall be Class "A" 0-25.

(2) Floor materials shall be easily cleanable and have wear resistance appropriate for the location involved. In all areas frequently subject to wet cleaning methods, floor materials shall not be physically affected by germicidal and cleaning solutions.

Floors that are subject to traffic while wet, such as shower and bath areas and certain work areas, shall have a nonslip surface.

(3) Wall finishes shall be washable and, in the immediate area of plumbing fixtures, shall be smooth and moisture resistant.

(4) Wall bases in soiled workrooms and other areas which are frequently subject to wet cleaning methods shall be made integral and coved with the floor.

(5) Duct linings shall not be used in systems supplying operating rooms and recovery rooms.

I. Air Conditioning, Heating and Ventilating Systems. (1) Temperatures and humidities. (a) The systems shall be designed to provide the following temperatures and humidities in the areas noted:

<i>Area Designation</i>	<i>Temperature °F</i>	<i>Relative Humidity (%)</i>	
		<i>Min.</i>	<i>Max.</i>
Operating Rooms	70-76	50	60
Recovery Rooms	70-76	50	60

(2) Ventilation system details. All air-supply and air-exhaust systems shall be located at the discharge end of the system. The ventilation rates shown in table 1 shall be considered as minimum acceptable rates and shall not be construed as precluding the use of higher ventilation rates.

(a) Outdoor intakes shall be located as far as practical but not less than twenty-five feet, zero inches (25'-0") from exhaust outlets of ventilating systems, combustion equipment stacks, medical-surgical vacuum systems, plumbing vents stacks, or from areas which may collect vehicular exhaust and other noxious fumes. The bottom of outdoor air intakes serving central systems shall be located as high as practical but not less than six feet, zero inches (6'-0") above ground level, or if installed above the roof, three feet, zero inches (3'-0") above the roof level.

(b) The ventilation systems shall be designed and balanced to provide the pressure relationship as shown in table No. 1.

Table I. General Pressure Relationships and Ventilation of Certain Out-Patient Surgical Areas

<i>Area Designation</i>	<i>Pressure Relationship to Adjacent Areas</i>	<i>Minimum Air Changes of Outdoor Air per hour Supplied to Room</i>	<i>Minimum Total Air Changes per Hour Supplied to Room</i>	<i>All Air Exhausted Directly to Outdoors</i>	<i>Recirculated within Room Units</i>
Legend: P = Positive, E = Equal, N = Negative					
Operating Room	P	5	25	Optional	No
Examination and Treatment Room	E	2	6	Optional	Optional
Recovery Room	P	2	6	Optional	No
Examination Room	E	2	6	Optional	Optional
Medication Room	P	2	4	Optional	Optional
Treatment Room	E	2	6	Optional	No
X-ray, Fluorosc-copy Rm.	N	2	6	Yes	No
X-ray, Treatment Rm.	E	2	6	Optional	Optional
Soiled Workroom	N	2	10	Yes	No
Clean Workroom	P	2	4	Optional	Optional
Darkroom	N	2	10	Yes	No
Toilet Room	N	Optional	10	Yes	No
Bathroom	N	Optional	10	Yes	No
Janitors' Closet	N	Optional	10	Yes	No
Sterilizer Equip-ment Room	N	Optional	10	Yes	No
Laboratory, Gen-eral	N	2	6	Optional	Optional
Anesthesia Stor-age (Flammable)	E	Optional	8	Yes	No
Central Medical and Surgical Supply Soiled or Decontam-ination Room	N	2	6	Yes	No
Clean Workroom	P	2	4	Optional	Optional
Unsterile Supply Storage	E	2	2	Optional	Optional

(c) All air supplied to operating rooms, shall be delivered at or near the ceiling of the area served, and all exhaust air from the area shall be removed near flood level. At least two exhaust outlets shall be used in all operating and delivery rooms.

(d) Corridors shall not be used to supply air to or exhaust air from any room.

(e) All central ventilation or air conditioning systems shall be equipped with filters having efficiencies no less than those specified in table No. 2. Where two filter beds are required, filter bed No. 1 shall be located upstream of the air conditioning equipment and filter bed No. 2 shall be located downstream.

Table 2. Filter Efficiencies for Central Ventilation and Air Conditioning Systems in Out-Patient Surgery Facilities

<i>Area Designation</i>	<i>Minimum Number of Filter Beds</i>	<i>Filter Efficiencies (Percent)</i>	
		<i>Filter Bed No. 1</i>	<i>Filter Bed No. 2</i>
Sensitive Areas (Includes operating rooms and recovery rooms)	2	25	90

Where only one filter bed is required, it shall be located upstream of the air conditioning equipment unless an additional prefilter is employed. In this case, the prefilter shall be upstream of the equipment and the main filter may be located further downstream.

(f) A manometer shall be installed across each filter bed serving sensitive areas or central air systems.

(g) Air handling duct systems shall meet the requirements of NFPA Standard 90A.

J. Electrical Requirements. (1) Lightning. (a) All spaces occupied by people, machinery, and equipment within buildings, approaches to buildings, and parking lots shall have lighting.

(b) A portable or fixed examination light shall be provided in each examination and treatment room.

(c) Operating rooms shall have general lighting in addition to local lighting provided by special lighting units at the surgical tables. Each special lighting unit at the tables, except for portable units, shall be connected to an independent circuit. Supplemental self contained emergency battery light units, with battery, trickle charger, supervisory and monitoring systems and controls shall be provided in each operating room.

(2) Receptacles (Convenience Outlets). (a) Anesthetizing locations. Each operating room shall have at least three receptacles of the types described in NFPA Standard 56A. In locations where mobile X-ray is used, an additional receptacle, distinctively marked for X-ray use, shall be provided.

(b) Rooms. Duplex grounding type receptacles shall be installed in all areas in sufficient quantities for the tasks to be performed. A minimum of one duplex receptacle for each wall shall be installed in each work area or room other than storage or lockers. Each examination and work table shall have access to a minimum of two duplex receptacles.

(c) All electrical receptacles in examination, treatment, procedure, recovery and utility rooms, shall be a hospital grade type.

(3) Equipment Installation in Special Areas. (a) X-ray Installations. Fixed and mobile X-ray equipment installations shall conform to article 660 of NFPA Standard 70.

(4) Emergency Electric Service. (a) General. To provide electricity during an interruption of the normal electric supply, an emergency source of electricity shall be provided and connected to certain circuits for lighting and power in accordance with NFPA 76A.

(b) Sources. The source of this emergency electric service shall be: Emergency generating set. The required emergency generating set, including the prime mover and generator, shall be located on the premises and shall be reserved exclusively for supplying the emergency electrical system.

(c) Emergency electrical connections. Emergency electric service shall be provided to the distribution systems as follows: Circuits for the safety of patients and personnel.

(A) Illumination of means of egress as required in NFPA Standard 101.

(B) Illumination for exit signs and exit directional signs as required in NFPA Standard 101.

(C) Alarm systems including fire alarms and alarms required for nonflammable medical gas systems if installed.

(D) Paging or speaker systems if intended for communication during emergency.

(d) Circuits essential to care, treatment, and protection of patients. (A) Task illumination and selected receptacles; drug distribution stations; operating and recovery rooms; treatment rooms; and nurses' stations.

(B) Nurses' calling system.

(C) Blood bank refrigeration, if provided.

(D) Equipment necessary for maintaining telephone service.

(e) Circuits which serve necessary equipment. (A) Ventilation of operating rooms.

(B) Central suction systems serving medical and surgical functions.

(C) Equipment which must be kept in operation to prevent damage to the building or its contents.

(5) Details. The emergency electrical system shall be so controlled that after interruption of the normal electric power supply the generator is brought to full voltage and frequency. It must be connected within ten seconds through one or more primary automatic transfer switches to emergency lighting systems; alarm systems; blood bank; nurses' calling systems; equipment necessary for maintaining telephone service; and task illumination and receptacles in operating, emergency, recovery, and other critical patient areas. All other lighting and equipment required to be connected to the emergency system shall either be connected through the above described primary automatic transfer switches or through other automatic or manual transfer switches. Receptacles connected to the emergency system shall be distinctively marked. Storage-battery-powered lights, provided to augment the emergency lighting or for continuity of lighting during the interim of transfer switching immediately following an interruption of the normal service supply, shall not be used as a substitute for the requirement of a generator. Where stored fuel is required for emergency generator operation, the storage capacity shall be sufficient for not less than twelve hour continuous operation.

(6) Generator set locations shall be protected from the elements and against tampering.

K. Fire Alarm Systems. A manually operated electrically supervised fire alarm system shall be installed in each facility.

(c) **Ownership and Administration.** (1) There shall be an organized governing authority with full legal authority and responsibility for the conduct of the surgical facility in a manner consonant with the objective of making available high quality patient care.

(2) Full and complete information shall be made available to the survey agency regarding the identity of each individual, group or corporation which has an ownership interest of ten percent or more in the facility.

(3) The governing authority shall have by-laws which shall identify the purposes of the facility, and the means of attaining them, which by-laws shall be dated, signed, and indicate periodic review and revision. These shall be available to all members of the governing body and all individuals to whom authority is delegated.

(4) These governing authority by-laws shall as a minimum contain: (A) A delineation of the powers and duties of the officers, committees of the governing body and the chief executive officer.

(B) The qualifications for membership, the method of selection and the terms of office of members and chairmen of committees.

(C) A description of the authority delegated to the chief of medical staff or clinical director and the medical staff as a whole.

(D) A mechanism for approval of the appointments and annual reappointments of the members of the medical-surgical staff recommended by the medical-surgical staff to the governing body.

(E) A mechanism for the delineation and control of medical-surgical privileges and anesthesia privileges of members of the medical-surgical staff recommended by the medical-surgical staff to the governing body. This shall be based upon background, experience and demonstrated competence, adherence to the ethics of the profession and appropriate physical and mental health.

(5) The governing body shall approve the medical staff by-laws, its organizational structure and all rules and regulations.

(6) The governing body shall demonstrate an interest and understanding of the activities of the surgicenter: Fiscal; building and maintenance; and clinical.

(7) (A) The governing body shall have regular meetings, not less than four times a year and so often as its responsibilities require.

(B) The minutes of the governing body meetings will be recorded, dated, approved and signed.

(d) **Chief Executive Officer.** (1) The governing body shall appoint a chief executive officer or administrator of the surgicenter who shall be qualified by education and experience appropriate to the discharge of his responsibilities.

(2) He shall be accountable to the governing body for his actions.

(3) His duties shall include the overall management of the operations of the facility, including the liaison and coordination of activities between the governing body and the medical and nursing staff.

(4) He shall be a member of the governing body and shall attend all meetings of the governing body and medical staff.

(e) **Professional Staff.** (1) **Clinical Director.** (A) The governing body shall appoint a clinical director, or chief of staff, accountable to it for his actions.

(B) He shall be qualified by training, demonstrated competence and judgment to manage the medical functions of the staff.

(C) He shall be delegated the authority to control the quality of medical-surgical care provided and to assure the effective discharge of the quality control review function of medical care.

(D) The members of the professional staff of the facility shall meet the requirements of Section 20-9 of the Connecticut General Statutes regarding who may practice medicine and surgery.

(E) Shall be qualified by training and experience to perform the duties assigned.

(F) Shall also have privileges in a hospital licensed in Connecticut to perform the duty or procedure which will be done at the surgicenter.

(2) All appointments, reappointments and privileges will be granted by the governing body with recommendations from the medical staff.

(3) All appointments, reappointments and specific privileges granted to the medical-surgical staff will be recorded in the minutes of meetings of the governing body or of the medical staff and filed in the doctor's medical profile with an agreement signed by the physician to abide by the hospital by-laws, medical staff by-laws and rules and regulations.

(4) The medical staff shall develop medical staff bylaws, rules and regulations to govern its organization and conduct, which shall include, but not be limited to the following:

(A) The officers of the medical staff, their duties, the qualifications for office, the term of office, the method of selection;

(B) The basis on which recommendations will be made to the governing body regarding the appointments, reappointments and the privileges of staff members;

(C) The committee structure of the medical staff;

(D) The mechanism by which medical care will be assessed including the development and implementation of a medical care evaluation program. In accordance with the current requirements of the Joint Commission on Accreditation of Hospitals and the Professional Standards Review Organization in which:

(a) Standards, norms, and criteria for care are developed for problems or disease categories.

(b) The actual care provided is measured against these standards, norms and criteria in a study of patterns of care for these specific problems or disease entities.

(c) A judgment or evaluation is made in the medical evaluation or audit procedure.

(d) Appropriate action, as indicated, is taken and documented for observed variations and deficiencies in care as determined by the audit process.

(e) The review to determine the appropriate utilization of facilities and equipment.

(f) The development of a program to control facility associated infections.

(g) The development of a program to control the distribution and use of drugs and therapeutics; in accordance with the requirements of the State Department of Consumer Protection, Drug Control Division, and all applicable state and federal drug laws and regulations.

(h) Requirements assuring that medical records shall be prepared and adequately maintained on each patient so as to explain and justify treatment and outcome.

(5) There shall be regular meetings of the medical-surgical staff with required attendance, except with appropriate justification of all physicians given privileges in the unit. The minutes of these meetings shall be recorded and shall reflect concern with the clinical care provided.

(6) At all times that there are patients in the unit there shall be a licensed physician on the premises.

(7) (A) The professional medical, surgical and nursing staff shall develop policies and procedures to assure high standards of professional practice on the unit. These shall be adopted, approved, placed in a manual made readily available for use by all professional staff and reviewed at least once a year, and as indicated, and revised as indicated.

(B) Specific policies and/or procedures shall include, but not be limited to the following areas:

(a) Requirement for, and necessary elements of, the pre-operative evaluation of the physical condition of all patients by a physician within a specific period before admission;

(b) The necessary pre and postoperative tests;

(c) The categories of acceptable admission diagnoses and unacceptable admission diagnoses;

(d) Operating hours, method of selection of patients relative to age, sex, physical status;

(e) Requirements for written pre-operative and postoperative instructions to be explained to patients;

- (f) Requirements for valid operative permits and signed informed consent forms;
 - (g) Operative procedures to be permitted and operative procedures to be excluded;
 - (h) Types of anesthesia that may be employed for specific procedures;
 - (i) Policies regarding use of laboratory tests, detection tests, treatment modalities and protective measures;
 - (j) Guidelines covering emergency care;
 - (k) Requirements that patients' status shall be deemed appropriate prior to discharge as regards vital signs, voiding, temperature and other significant elements;
 - (l) Requirement that each patient is to have a responsible person available to accompany him or her on discharge unless otherwise authorized by a physician;
 - (m) Required policies relating to quality control, which include review and evaluation of surgical, anesthesiology and nursing practice as well as case review and review of patterns of care;
 - (n) A requirement that all tissue removed at surgery shall be submitted to a qualified licensed pathologist. Examinations will be performed on these tissues according to an established procedure approved by the pathologist and the medical director. The disposition of the tissue or the pathological report shall be appended to the patient record;
 - (o) Establishment of written agreements with hospital(s) in the immediate vicinity in the event it becomes necessary to transfer a patient(s);
 - (p) Policies regarding prevention and control of infections among patients and staffs;
 - (q) Appropriate referral and follow-up on patients and cooperative arrangements with referring physicians.
- (8) Laboratory and Radiology. (A) Laboratory work performed shall be under the supervision of a qualified licensed pathologist, or shall be done by a licensed laboratory.
- (B) A qualified licensed radiologist shall supervise all radiological procedures.
- (9) Anesthesia Services. The anesthesia services of the unit shall be under the supervision of a qualified anesthesiologist who shall be delegated the authority to:
- (A) Oversee the quality of anesthesia care provided by anesthesia personnel employed by the unit;
 - (B) Assure the availability and proper functioning of such equipment as is necessary to administer anesthesia, and to provide necessary resuscitative measures including emergency cardiopulmonary resuscitation;
 - (C) Develop regulations to assure anesthetic safety and recovery room patient support;
 - (D) Administer a retrospective review of all anesthesia care. The anesthesiologist in charge shall have a major role in the development of policies and procedures to assure the satisfactory preanesthetic status of patients, including the decision regarding choice of anesthesia, preoperative medication, postoperative recovery room supervision, and suitable discharge status.
- (f) **Records and Reports.** (1) There shall be adequate provision for the retention and storage of all clinical records which shall ensure the safety of such records and the confidentiality of the information contained therein.
- (2) Adequate space and equipment shall be provided for record keeping.
 - (3) A clinical record shall be started for each patient at the time of admission to the unit to include all appropriate and proper identifying data. Each patient's record shall contain sufficient information to justify the diagnosis and warrant the treatment

given or services provided. Each entry in the record shall be signed by the person responsible for it immediately after service is rendered.

(4) All records shall be maintained in a safe manner for a minimum of five years following the discharge of the patient.

(5) The unit shall collect, retrieve and summarize data relating to program evaluation and in planning to meet needs of patients. This data should include at least the following: Total number of visits; number of patients seen; diagnosis; types and numbers of operative procedures performed; age distribution of patients; death and other untoward accidents or incidents. This report to be prepared on an annual basis and be available for review by the state department of health.

(6) There shall be an anesthesia record for each patient who receives anesthesia on the unit. This shall become a part of the medical record and shall include patient identification data, dosage and duration of anesthesia, a record of administration of other drugs or therapeutics.

(g) **Nursing Staff.** (1) There shall be appointed as supervisor of the unit a registered nurse with a current license to practice in Connecticut. She/he should have special education and experience in operating and recovery room care. Qualifications of the supervisor and other personnel shall be verified in the form of listing current license numbers and in written job descriptions.

(2) If the unit is opened for a period of time beyond the normal work week of the R.N. supervisor and/or in her absence, an additionally qualified person shall be available to be responsible for nursing services in the unit at these times.

(3) In addition to the supervisor there shall be additional licensed nurses with special training in surgery and recovery room care available. These additional personnel may serve as assistant or backup personnel under the direct supervision of a qualified registered nurse. A minimum of one registered nurse, in addition to the supervisor must be available at all times when there are patients in the unit. The minimum staffing ratio shall be such as to assure the provision of sufficient and adequate nursing care for the comfort, safety and welfare of all patients.

(h) **Additional Personnel.** (1) All housekeeping and cleaning staff shall have and receive special training to ensure that technical procedures used in cleaning and housecleaning are developed and implemented to protect patients' health and safety.

(2) There shall be either available on staff or arrangements made for, the assistance of social workers, dietitians, psychologicals and other professional staff as deemed necessary for the care of the patient.

(i) **General.** (1) There shall be job descriptions indicating qualifications, training and/or past experience and responsibilities relating to the care of patients and/or equipment used in units for all personnel.

(2) There shall be a program of continuing staff education provided on a regularly scheduled basis in order to maintain and improve skills.

(3) There shall be appropriate sterilizing equipment of steam pressure type available. The size of the equipment shall be dependent upon the amount of pre-sterilized disposable equipment used in the unit.

(4) There shall be emergency equipment and drugs for resuscitation and defibrillation.

(5) The management, operation, personnel, equipment, facilities, sanitation and maintenance of the unit shall be such as reasonably to ensure the health and safety of public patients and staff at all times.

(6) Written fire and disaster plans shall be formulated and posted in a conspicuous location.

(j) **Disaster Plan.** The surgical unit shall develop a plan to cope with internal disasters including fire and loss of power. This plan shall include:

- (1) The assignment of personnel to specific duties;
- (2) Instruction in use of fire alarms, fire equipment and systems for notification of key personnel;
- (3) Instructions in methods of fire containment;
- (4) Procedures for evacuation of patients. Fire disaster drills shall be held at regular intervals, not less than quarterly including evacuation procedures to assure the effectiveness of these plans.

(k) **Inspection and Licensure.** The ambulatory surgical facility shall be inspected annually by the state department of health to test for ongoing compliance with these regulations.

(Effective April 22, 1977)

Sec. 19-13-D57.

Repealed, August 20, 1982.

Secs. 19-13-D58—19-13-D59. Reserved

**Public Health Nursing Grants to Towns Having
Population of Less Than Five Thousand**

Secs. 19-13-D60—19-13-D64.

Repealed, March 5, 1998.

Home Health Care Agency

Sec. 19-13-D65. Reserved

Licensure of Home Health Care Agencies

Sec. 19-13-D66. Definitions

As used in Sections 19-13-D66 to 19-13-D79 inclusive:

- (a) "Agency" means home health care agency as defined in Section 19a-490 of the Connecticut General Statutes;
- (b) "Central Office" means the agency office responsible and accountable for all agency operations in this state;
- (c) "Clinical experience" means employment in providing patient services in a health care setting;
- (d) "Commissioner" means the commissioner of health services, or his/her representative;
- (e) "Contracted services" or "services under arrangement" means services provided by the agency which are subject to a written agreement with an individual, another agency or another facility;
- (f) "Contractor" means any organization, individual or home health care agency that provides services to patients of a primary agency as defined in paragraph (cc) of Section 19-13-D66 of these regulations;
- (g) "Chiropractor" means a person possessing a license to practice chiropractic in this state;
- (h) "Curriculum" means the plan of classroom and clinical instructions for training and skills assessment as a homemaker-home health aide;

- (i) "Dentist" means a person licensed to practice dentistry in this state;
- (j) "Department" means the Connecticut Department of Health Services;
- (k) "Direct service staff" means individuals employed by the agency or under contract whose primary responsibility is delivery of care to patients;
- (l) "Evening or nighttime service" means service provided between the hours of 5 p.m. and 8 a.m.;
- (m) "Full-time" means employed and on duty a minimum of thirty-five (35) hours per workweek on a regular basis;
- (n) "Full-time equivalent" means the total weekly hours of work of all persons in each category of direct service staff divided by the number of hours in the agency's standard workweek. Full-time equivalents are computed for each category of direct service staff;
- (o) "Holiday service" means service provided on the days specified in the agency's official personnel policies as holidays;
- (p) "Homemaker-home health aide" means an unlicensed person who has successfully completed a training and competency evaluation program for the preparation of homemaker-home health aides approved by the department;
- (q) "Licensed practical nurse" means a person with a license to practice practical nursing in this state;
- (r) "Non-visiting program" means services of the agency provided in sites other than a patient's home;
- (s) "Occupational therapist" means a person with a license to practice occupational therapy in this state;
- (t) "Occupational therapy assistant" means a person who has successfully completed a training program approved by the American Occupational Therapy Association and is currently certified by the said association;
- (u) "Patient care services" mean agency activities carried out by agency staff for or on behalf of a patient. Such services include, but are not limited to, receipt of referral for service, admission to service, assignment of personnel, direct patient care, communication/coordination with source of medical care and development/maintenance of patient's clinical record;
- (v) "Patient service office" means one or more separate and distinct offices which provide patient care services and are included under the agency's license. This office shall comply with the regulations of Connecticut State Agencies, Section 19-13-D77;
- (w) "Peer consultation" means a process by which professionals of the same discipline, who meet supervisory qualifications, meet regularly to review patient management, share expertise and take responsibility for their own and each other's professional development and maintenance of standards of service;
- (x) "Permanent part-time" means employed and on duty a minimum of twenty (20) hours per workweek on a regular basis;
- (y) "Pharmacist" means a person licensed to practice pharmacy in this state;
- (z) "Physical therapy assistant" means a person who has successfully completed an education program accredited by the American Physical Therapy Association;
- (aa) "Physician" means a doctor of medicine or osteopathy licensed either in Connecticut or in a state which borders Connecticut;
- (bb) "Podiatrist" means a person licensed to practice podiatry in this state;
- (cc) "Primary agency" means a home health care agency which hires or pays for the services of other organizations, agencies or individuals who provide care or services to its patients;

(dd) “Primary care nurse” means a registered nurse licensed to practice nursing in this state who is the agency employee assigned primary responsibility for planning and implementing the patient’s care;

(ee) “Public health nurse” means a graduate of a baccalaureate degree program in nursing approved by the National League for Nursing for preparation in public health nursing;

(ff) “Quality care” means that the patients receive clinically competent care which meets professional standards, are supported and directed in a planned pattern toward mutually defined outcomes, achieve maximum recovery consistent with individual potential and life style, obtain coordinated service through each level of care and are taught self-management and preventive health measures;

(gg) “Registered nurse” means a person with a license to practice as a registered nurse in this state;

(hh) “Registered physical therapist” means a person with a license to practice physical therapy in this state;

(ii) “Related community health program” means an organized program which provides health services to persons in a community setting;

(jj) “Representative” means a designated member of the patient’s family, or person legally designated to act for the patient in the exercise of the patient’s rights as contained in Sections 19-13-D66 to 19-13-D79 of the regulations of Connecticut State Agencies.

(kk) “Social work assistant” means a person who holds a baccalaureate degree in social work with at least one (1) year of social work experience; or a baccalaureate degree in a field related to social work with at least two (2) years of social work experience;

(ll) “Social worker” means a graduate of a master’s degree program in social work accredited by the Council on Social Work Education;

(mm) “Speech Pathologist” means a person with a license to practice speech pathology in this state;

(nn) “Subdivision” means a unit of a multifunction health care organization which is assigned the primary authority and responsibility for the agency operations. A subdivision shall independently meet the regulations and standards for licensure and shall be independently licensed as a home health care agency;

(oo) “Therapy services” means physical therapy, occupational therapy, or speech pathology services;

(pp) “Weekend service” means services provided on Saturday or Sunday.

(Effective December 28, 1992)

Sec. 19-13-D67. Personnel

(a) The administrator of an agency shall be a person with one of the following:

(1) A master’s degree in nursing with an active license to practice nursing in this state and at least one (1) year of supervisory or administrative experience in a health care facility program which included care of the sick; or

(2) A master’s degree in public health or administration with a concentration of study in health services administration, and at least one (1) year of supervisory or administrative experience in a health care facility/program which included care of the sick; or

(3) A baccalaureate degree in nursing with an active license to practice nursing in this state and at least two (2) years supervisory or administrative experience in a health care facility/program which included care of the sick; or

(4) A baccalaureate degree in administration with a concentration of study in health services administration and at least two (2) years' supervisory or administrative experience in a health care facility/program which included care of the sick; or

(5) A physician licensed to practice medicine and surgery in the State of Connecticut who has had at least one (1) year supervisory or administrative experience in a health care facility/program which included care of the sick; or

(6) Employment as the administrator of a home health care agency in this state as of January 1, 1981, who has been so employed continuously for the five (5) years immediately preceding January 1, 1981; or

(7) Continuous employment as an administrator of a home health care agency as of January 1, 1979; except that on and after January 1, 1986, no person shall be employed as an administrator of a home health care agency pursuant to this subdivision unless such person additionally meets one of the requirements of subparagraphs (1) through (5) inclusive above.

(b) An agency supervisor of clinical services shall be a registered nurse with an active license to practice nursing in this state, and shall have one of the following:

(1) A master's degree from a program approved by the National League for Nursing or the American Public Health Association with a minimum of one year (1) full-time clinical experience in a home health agency or related community health program which included care of the sick at home; or

(2) A baccalaureate degree in nursing and a minimum of three (3) years of full-time clinical experience in nursing, at least (1) one of which was in a home health agency or community health program which included care of the sick at home; or

(3) A registered nurse who has been continuously employed in the position of supervisor of clinical services in a home health agency in this state since January 1, 1979; or

(4) A diploma in nursing or an associates degree in nursing and

(A) A minimum of three years of full-time or full-time equivalent clinical experience in nursing within the past five years, at least one year of which was in a home health care agency or community health program which included care of the sick at home; and

(B) Evidence of certification by the American Nurses' Association as a community health nurse or completion of at least six credits received within two years in community health nursing theory or six credits in health care management from an accredited college or university program or school of nursing.

(c) An agency supervisor of physical therapy services shall be a registered physical therapist licensed to practice physical therapy in this state who has a minimum of three (3) years' clinical experience in physical therapy.

(d) An agency supervisor of occupational therapy services shall be an occupational therapist licensed to practice occupational therapy in this state who has a minimum of three (3) years' clinical experience in occupational therapy.

(e) An agency supervisor of speech pathology services shall be a speech pathologist licensed to practice speech pathology in this state who has a minimum of three (3) years' clinical experience in speech pathology.

(f) An agency supervisor of social work services shall be a graduate of a master's degree program in social work accredited by the Council on Social Work Education who has a minimum of three (3) years' clinical experience in social work.

(Effective April 24, 1989; amended August 31, 1998)

Sec. 19-13-D68. General requirements

An agency shall be organized and staffed in compliance with the following:

(a) The agency shall be governed by a governing authority, maintain an active professional advisory committee, be directed by an administrator and operate any services offered in compliance with these regulations. Compliance with these regulations shall be the joint and several responsibility of the governing authority and the administrator.

(b) **Governing Authority:**

(1) There shall be a formal governing authority with full legal authority and responsibility for the operation of the agency which shall adopt bylaws or rules that are periodically reviewed and so dated. Such bylaws or rules shall include, but are not limited to:

(A) Purposes of the agency;

(B) Delineation of the powers, duties and voting procedures of the governing authority, its officers and committees;

(C) Qualifications for membership, method of selection and terms of office of members and chairpersons of committees;

(D) A description of the authority delegated to the administrator;

(E) The agency's conflict of interest policy and procedures.

(2) The bylaws or rules shall be available to all members of the governing authority and all individuals to whom authority is delegated.

(3) The governing authority shall:

(A) Meet as frequently as necessary to fulfill its responsibilities as stated in these regulations, but no less than one (1) time per year;

(B) Provide a written agenda and minutes for each meeting;

(C) Provide that minutes reflect the identity of those members in attendance and that, following approval, such minutes be dated and signed by the secretary;

Ensure that the agenda and minutes of any of its meetings or any of its committees are available at any time to the commissioner.

(4) Responsibilities of the governing authority include, but are not limited to:

(A) Services provided by the agency and the quality of care rendered to patients and their families;

(B) Selection and appointment of a professional advisory committee;

(C) Policy and program determination and delegation of authority to implement policies and programs;

(D) Appointment of a qualified administrator;

(E) Management of the fiscal affairs of the agency;

(F) The quality assurance program.

(5) The governing authority shall ensure that:

(A) The name and address of each officer and member of the governing authority are reported to the commissioner annually;

(B) The name and address of each owner and, if the agency is a corporation, all ownership interests of ten percent (10%) or more (direct or indirect) are reported to the commissioner annually;

(C) Any change in ownership is reported to the commissioner within ninety (90) days;

(D) The name of the administrator of the agency is forwarded to the commissioner within three (3) days of his/her appointment and notice that the administrator has left for any reason is so forwarded within forty-eight (48) hours.

(c) **Professional Advisory Committee:**

(1) There shall be a professional advisory committee, appointed by the governing authority, consisting of at least one physician, one public health nurse, one therapist representing at least one of the skilled therapy services provided by the agency and one social worker. Representatives appointed to the professional advisory committee shall be in active practice in their professions, or shall have been in active practice within the last five (5) years. No member of the professional advisory committee shall be an owner, stockholder, employee of the agency, or related to same, including by marriage. However, provision may be made for employees to serve on the professional advisory committee as ex officio members only, without voting power.

(2) The functions of the professional advisory committee shall be to participate in the agency's quality assurance program to the extent defined in the quality assurance program policies and to recommend and at least annually review agency policies on:

- (A) Scope of services offered;
- (B) Admission and discharge criteria;
- (C) Medical and dental supervision and plans of treatment;
- (D) Clinical records;
- (E) Personnel qualifications;
- (F) Quality assurance activities;
- (G) Standards of care;
- (H) Professional issues especially as they relate to the delivery of service and findings of the quality assurance program.

(3) The professional advisory committee shall hold at least two (2) meetings annually.

(4) Written minutes shall document dates of meetings, attendance, agenda and recommendations. The minutes shall be presented, read and accepted at the next regular meeting of the governing authority of the agency following the professional advisory committee meeting. These minutes shall be available at any time to the commissioner.

(d) Administrator:

(1) There shall be a full-time agency administrator appointed by the governing authority of the agency.

(2) The administrator shall have full authority and responsibility delegated by the governing authority to plan, staff, direct and implement the programs and manage the affairs of the agency. The administrator's responsibilities include, but are not limited to:

- (A) Interpretation and execution of the policies of the governing authority;
- (B) Program planning, budgeting, management and evaluation based upon
- (C) Maintenance of ongoing liaison among the governing authority, its committees, the professional advisory committee and staff;
- (D) Employment of qualified personnel, evaluation of staff performance per agency policy, provision of planned orientation and inservice education programs for agency personnel;
- (E) Development of a record system and statistical reporting system for program documentation, planning and evaluation, which includes at least the data specified in these regulations;
- (F) Preparation of a budget for the approval of the governing authority and implementation of financial policies, accounting system and cost controls;
- (G) Assurance of an accurate public information system;

(H) Maintenance of the agency’s compliance with licensure regulations and standards;

(I) Distribution of a written plan for the delegation of administrative responsibilities and functions in the absence of the administrator.

(3) An administrator’s absence of longer than one month shall be reported to the commissioner.

(e) Supervisor of Clinical Services;

(1) An agency shall employ one full-time supervisor of clinical services for each fifteen (15), or less, full-time or full-time equivalent professional direct service staff.

(2) The supervisor of clinical services shall have primary authority and responsibility for maintaining the quality of clinical services.

(3) The supervisor’s responsibilities include, but are not limited to:

(A) Coordination and management of all services rendered to patients and families by direct service staff under his/her supervision;

(B) Supervision of assigned nursing personnel in the delivery of nursing services to patients and families;

(C) Direct evaluation of the clinical competence of assigned nursing personnel and participation with appropriate supervisory staff in the evaluation of other direct service staff;

(D) Participation in or development of all agency objectives, standards of care, policies and procedures affecting clinical services;

(E) Participation in direct services staff recruitment, selection, orientation and inservice education;

(F) Participation in program planning, budgeting and evaluation activities related to the clinical services of the agency.

(4) The supervisor of clinical services may also serve as the administrator in agencies with six (6) or less full-time or full-time equivalent professional direct service staff.

(5) Any absence of the supervisor of clinical services for longer than one month must be reported to the commissioner. A registered nurse who has at least two (2) years’ experience in a home health care agency, shall be designated, in writing, to act during any absence of the supervisor of clinical services whenever patient care personnel are serving patients.

(Effective June 21, 1983)

Sec. 19-13-D69. Services

Services offered by the agency shall comply with the following.

(a) Nursing Service:

(1) An agency shall have written policies governing the delivery of nursing service.

(2) Nursing service shall be provided by a primary care nurse, or other nursing staff delegated by the primary care nurse.

(3) The primary care nurse is responsible for the following which shall be documented in the patient’s clinical record:

(A) Admission of patients for service and development of the patient care plan;

(B) Implementation or delegation of responsibility for twenty-four (24) hour nursing service and homemaker-home health aide services;

(C) Coordination of services with the patient, family and others involved in the care plan;

(D) Regular evaluation of patient progress, prompt action when any change in the patient’s condition is noted or reported, and termination of care when goals of management are attained;

(E) Identification of patient and family needs for other home health services and referral for same when appropriate,

(F) Participation in orientation, teaching and supervision of other nursing and ancillary patient care staff;

(G) Determination of aspects of the care plan for delegation to a homemaker-home health aide. Whenever any patient care activity, other than those activities listed in section 19-13-D69 (d) (3) of these regulations, is delegated to a homemaker-home health aide, the patient's clinical record clearly supports that the primary care nurse or designated professional staff member has:

(i) Assessed all factors pertinent to the patient's safety including the competence of the homemaker-home health aide, and

(ii) Determined that this activity can be delegated safely to a homemaker-home health aide.

(H) Development of a written plan of care and instructions for homemaker-home health aide services;

(I) Arranging supervision of the homemaker-home health aide by other therapists, when necessary

(J) Visiting and completing an assessment of assigned patients receiving homemaker-home health aide services as often as necessary based on the patient's condition, but not less frequently than every sixty (60) days. The sixty-day assessment shall be completed by a registered nurse, while the homemaker-home health aide is providing services in the patient's home.

(4) An agency may employ licensed practical nurses under the direction of a registered nurse to provide nursing care, to assist the patient in learning self-care techniques and to prepare clinical and progress notes.

(b) Therapy Services:

(1) An agency shall have written policies governing the delivery of therapy services.

(2) All therapy services shall be provided by or under the supervision of a therapist licensed to practice in Connecticut.

(3) The responsibilities of each therapist within his/her respective area of practice include the following, which shall be documented in the patient's clinical record:

(A) Comprehensive evaluation of patient's level of function and participation in development of the total patient care plan;

(B) Identification of patient and family needs for other home health services and referral for same when needed;

(C) Participation in case management conferences;

(D) Instruction of patient, family and other agency health care personnel in the patient's treatment regime when indicated;

(E) Supervision of therapy assistants; and

(F) Supervision of homemaker-home health aides when such personnel are participating in the patient's therapy regime.

(4) A therapy supervisor shall be provided for each therapy service, except when therapy staff meet supervisory requirements. In such event, the agency shall provide peer consultation for that therapy staff.

(A) Each supervisor shall be employed directly by the agency, or as a contractor.

(B) When the direct service therapy staff is five (5) full-time or full-time equivalent persons, the agency shall provide a full-time supervisor for that therapy staff. The number of staff assigned to a supervisor shall not exceed fifteen (15) full-time or full-time equivalent staff.

(5) Physical or occupational therapy assistants who function at all times under the direction of a registered physical therapist or occupational therapist, as appropriate, may be employed to carry out treatment regimes as assigned by the registered physical therapist or occupational therapist. The agency shall employ at least one (1) registered physical therapist or occupational therapist for every six (6) assistants or less.

(A) The responsibilities of the therapy assistant may include but not necessarily be limited to the following:

(i) After an initial visit has been made by the registered physical therapist or occupational therapist for evaluation of the patient and establishment of a patient care plan, the therapy assistant may provide ongoing therapy services in accordance with the established plan.

(ii) At least every thirty (30) days, the therapy assistant shall confer with the registered physical therapist or occupational therapist. The conference shall be documented in the patient's clinical record, and shall include a review of the current patient care plan and any appropriate modifications to the treatment regime.

(iii) The therapy assistant, with prior approval of the registered physical therapist or occupational therapist, may adjust a specific treatment regime in accordance with changes in the patient's status.

(iv) The therapy assistant may contribute to the review of the medical or dental plan of treatment required by subsection (b) of section 19-13- D73 of the regulations of Connecticut states agencies, pre-discharge planning and preparation of the discharge summary.

(B) A registered physical therapist or occupational therapist shall be accessible by phone and available to make a home visit at all times when the therapy assistant is on assignment in a patient's home.

(c) Social Work Services:

(1) An agency shall have written policies governing the delivery of social work services.

(2) All social work services shall be provided by or under the supervision of a qualified social worker.

(3) Functions of the social worker include the following which shall be documented in the patient's clinical record:

(A) Comprehensive evaluation of psychosocial status as related to the patient's illness and environment;

(B) Participation in development of the total patient care plan;

(C) Participation in case conferences with the health care team;

(D) Identification of patient and family needs for other home health services and referral for same when appropriate;

(E) Referral of patient or family to appropriate community resources.

(4) A qualified social work supervisor shall be employed directly by the agency or as a contractor, except when social work staff meet supervisory requirements. In such event, the agency shall provide peer consultation for social work staff.

When the direct service social work staff is five (5) full-time or full-time equivalent persons, the agency must provide a full-time supervisor. The number of staff assigned to a supervisor shall not exceed fifteen (15) full-time or full-time equivalent staff.

(5) Social work assistants who function at all times under the supervision of a qualified social worker may be employed to carry out the social work activities and assignments. The agency shall employ at least one (1) qualified social worker for every six (6) social work assistants or less.

(d) Homemaker-Home Health Aide Service:

(1) An agency shall have written policies governing the delivery of homemaker-home health aide services.

(2) On and after January 1, 1993, no person shall furnish home health aide services on behalf of a home health care agency unless such person has successfully completed a training and competency evaluation program approved by the department.

(A) The commissioner shall adopt, and revise as necessary, a homemaker-home health aide training program of not less than seventy-five (75) hours and competency evaluation program for homemaker-home health aides. The standard curriculum of the training program shall include the following elements which shall be presented in both lecture and clinical settings:

- (i) Communication skills;
- (ii) Observation, reporting and documentation of patient status and the care or services furnished;
- (iii) Reading and recording temperature, pulse and respiration;
- (iv) Basic infection control procedures;
- (v) Basic elements of body function and changes in body function that must be reported to an aide's supervisor;
- (vi) Maintenance of a clean, safe and healthy environment;
- (vii) Recognizing emergencies and knowledge of emergency procedures;
- (viii) The physical, emotional, and developmental needs of and ways to work with the populations served by the home health care agency, including the need for respect for the patient, his or her privacy and his or her property;
- (ix) Appropriate and safe techniques in personal hygiene and grooming that include: bath (bed, sponge, tub or shower), shampoo (sink, tub or bed), nail and skin care, oral hygiene, toileting and elimination;
- (x) Safe transfer techniques and ambulation;
- (xi) Normal range of motion and positioning;
- (xii) Adequate nutrition and fluid intake;
- (xiii) Any other task that the home health care agency may choose to have the homemaker-home health aide perform.

(B) A trainee's successful completion of training shall be demonstrated by the trainee's performance, satisfactory to the qualified registered nurse designated in subparagraph (I) (i) of this subdivision, of the elements required by the curriculum. Each agency that elects to conduct a homemaker-home health aide training program shall submit such information on its homemaker-home health aide training program as the commissioner may require on forms provided by the department. The department may re-evaluate the agency's homemaker-home health aide training program and competency evaluation program for sufficiency at any time.

(C) The commissioner shall adopt, and revise as necessary, a homemaker-home health aide competency evaluation program to include, procedures for determination of competency which may include a standardized test. At a minimum the subject areas listed in subparagraph (A) (iii), (ix), (x), and (xi) of this subdivision shall be evaluated through observation of the aide's performance of the tasks. The other subject areas in subparagraph (a) of this subdivision shall be evaluated through written examination, oral examination or observation of a homemaker-home health aide with a patient.

(D) A homemaker-home health aide is not considered competent in any task for which he or she is evaluated as "unsatisfactory." The homemaker-home health

aide must not perform that task without direct supervision by a licensed nurse until after he or she receives training in the task for which he or she was evaluated “unsatisfactory” and passes a subsequent evaluation with a “satisfactory” rating.

(E) A homemaker-home health aide is not considered to have successfully passed a competency evaluation if the homemaker-home health aide has an “unsatisfactory” rating in more than one of the required areas listed in subparagraph (A) of this subdivision.

(F) The competency evaluation must be performed by a registered nurse who possesses a minimum of two (2) years of nursing experience at least one (1) year of which must be in the provision of home health care.

(G) The state department of education, the board of trustees of community-technical colleges and an Adult Continuing Education Program established and maintained under the auspices of the local or regional board of education or regional educational service center and provided by such board or center may offer such training programs and competency evaluation programs in accordance with this subsection as approved by the commissioner.

(H) Home health care agencies may offer such training programs and competency evaluation programs in accordance with this subsection provided that they have not been determined to be out of compliance with one (1) or more of the training and competency evaluation requirements of OBRA as amended and/or one or more condition of participation of title 42, part 484 of the code of federal regulations within any of the twenty-four (24) months before the training is to begin.

(I) Qualifications of homemaker-home health aide training instructors

(i) The training of homemaker-home health aides must be performed by or under the general supervision of a registered nurse who possesses a minimum of two (2) years of nursing experience, one (1) year of which must be in the provision of home health care.

(ii) Personnel from the health field may serve as trainers in the homemaker-home health aide training program under the general supervision of the qualified registered nurse identified in subparagraph (I) (i) of this subdivision. All trainers shall be licensed, registered and/or certified in their field.

(iii) Licensed practical nurses, under the supervision of the qualified registered nurse designated in subparagraph (I) (i) of this subdivision may serve as trainers in the homemaker-home health aide training program provided the licensed practical nurse has two (2) years of nursing experience, one (1) year of experience which must be in the provision of home health care.

(iv) The training of homemaker-home health aides may be performed under the general supervision of the supervisor of clinical services. The supervisor of clinical services is prohibited from performing the actual training of homemaker-home health aides.

(J) Upon satisfactory completion of the training and competency evaluation program the agency or educational facility identified in subparagraph (G) of this subdivision shall issue documentation of satisfactory completion, signed by the qualified registered nurse designated in subparagraph (I) (i) of this subdivision, as evidence of said training and competency evaluation. Said documentation shall include a notation as to the agency or educational facility that provided the training and competency evaluation program.

(K) On and after January 1, 1993, any home health care agency that uses homemaker-home health aides from a placement agency or from a nursing pool shall

maintain sufficient documentation to demonstrate that the requirements of this subsection are met.

(L) If, since an individual's most recent completion of a training and competency evaluation program or 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 competency evaluation program.

(M) Any person employed as a homemaker-home health aide prior to January 1, 1993 shall be deemed to have completed a training and competency evaluation program pursuant to subdivision 19-13-D69 (d) (2) of the regulations of Connecticut State Agencies.

(N) Any person who has successfully completed prior to January 1, 1993 the state-sponsored nurse assistant training program provided through the state department of education or through the Connecticut Board of Trustees of community-technical colleges shall be deemed to have completed a homemaker-home health aide training and competency evaluation program approved by the commissioner in accordance with this subsection.

(O) Any person who completed a nurses aide training and competency evaluation program as defined in section 19-13-D8t (a) of the Regulations of Connecticut State Agencies shall be deemed to have completed a training program as required in this subsection. Such individual shall complete a homemaker-home health aide competency evaluation before the provision of homemaker-home health aide services.

(P) Any person who has successfully completed a course or courses comprising not less than seventy-five (75) 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 may be deemed to have completed a homemaker-home health 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, such individual shall complete a homemaker-home health aide competency evaluation before the provision of homemaker-home health aide services.

(Q) On or after January 1, 1993 a homemaker-home health aide in another state or territory of the United States may be deemed to have completed a training program as required in this section provided the home health care agency has sufficient documentation which demonstrates such individual has successfully completed a training program in accordance with subparagraph (2) (A) of this subsection. Such individual shall complete a homemaker-home health aide competency evaluation before the provision of homemaker-home health aide services.

(R) The home health care agency shall maintain sufficient documentation to demonstrate that all the requirements of this subsection are met for any individual furnishing homemaker-home health aide services on behalf of the home health care agency.

(S) Any person who has been deemed to have completed a homemaker-home health aide training program in accordance with this subsection shall be provided with ten (10) hours of orientation by the agency of employment prior to the individual providing any homemaker-home health aide services.

(3) When designated by the supervising primary care nurse, duties of the homemaker-home health aide may include:

(A) Assisting the patient with personal care activities including bathing, oral hygiene, feeding and dressing;

(B) Assisting the patient with exercises, ambulation, transfer activities and medications that are ordinarily self administered;

(C) Performing normal household services essential to patient care at home, including shopping, meal preparation, laundry and housecleaning.

(4) Supervision of homemaker-home health aides.

(A) A registered nurse shall be accessible by phone and available to make a home visit at all times, including nights, weekends and holidays, when homemaker-home health aides are on assignment in a patient's home.

(B) The primary care nurse assigned to the patient is responsible for supervision of the services rendered to the patient and family by the homemaker-home health aide.

(C) An agency shall designate a full-time registered nurse, who may have other responsibilities, to be responsible for supervision of the homemaker-home health aide program and staff when that staff is twenty-four (24) or less persons, but when the number of homemaker-home health aides employed is twenty-five (25) or more persons, the agency shall employ a full-time supervisor whose primary responsibility shall be management of the homemaker-home health aide program. If this supervisor is not a registered nurse, the agency shall designate one full-time registered nurse, who may have other responsibilities, to assist with homemaker-home health aide program and staff supervision.

(D) An agency shall maintain at least the following staffing pattern during the regular workweek: One (1) full-time registered nurse for every fifteen (15), or less, full-time equivalent homemaker-home health aides on duty.

(Effective December 28, 1992; amended August 29, 1996, August 31, 1998, July 3, 2007)

Sec. 19-13-D70. Contracted services

Home health care agencies may hire other organizations, agencies or individuals to provide services to home health care agency patients. Services provided by the primary agency through arrangements with a contractor agency or individuals shall be set forth in a written contract which clearly specifies:

(a) That the patient's contract for care is with the primary agency;

(b) The services to be provided by the contractor;

(c) The necessity to conform to all applicable primary agency policies, including personnel qualifications, supervisory ratios and staffing patterns;

(d) The responsibility for participating in developing the patient care plans;

(e) The procedures for submitting clinical and progress notes, scheduling visits, periodic patient evaluation, and determining charges and reimbursement;

(f) The procedure for annual assurance of clinical competence of all personnel utilized under contract;

(g) A term not to exceed one year.

(Effective June 21, 1983)

Sec. 19-13-D71. Personnel policies

(a) An agency shall have written personnel policies which include but are not limited to:

(1) Orientation policy and procedure. An agency orientation policy for all employees shall include but not be limited to review of the following:

(A) organizational structure of the agency;

(B) agency patient care policies and procedures;

(C) philosophy of patient care;

(D) description of client population and geographic area served;
 (E) agency personnel policies and job description;
 (F) applicable state and federal regulations governing the delivery of home health care services;

(G) The orientation dates, content, and name and title of the person providing the orientation shall be documented in the employee's personnel folder.

(2) In-service education policy which provides an annual average of at least one (1) hour per month for each employee serving patients. The in-service education shall include current information regarding drugs and treatments; specific service procedures and techniques; recognized professional standards, criteria and classification of clients served.

Agencies that employ homemaker-home health aides shall ensure that homemaker-home health aides attend in-service sessions. The in-service education program shall be provided under the supervision of the supervisor of clinical service or a designated registered nurse who possesses a minimum of two (2) years of nursing experience, at least one (1) year of which must be in the provision of home health care. On and after January 1, 1993 any home health care agency that utilizes a homemaker-home health aide from a placement agency or from a nursing pool shall maintain sufficient documentation to demonstrate these requirements are met.

(3) A policy and procedure for an annual performance evaluation, which includes a process for corrective action when an employee receives an unsatisfactory performance evaluation;

(4) Position descriptions;

(5) Physical examination, including tuberculin test and a physician's or his/her designee's statement that the employee is free from communicable diseases, must be prior to assignment to patient care activities.

(b) For all employees employed directly or by contracts with individuals the agency shall maintain individual personnel records containing at least the following:

(1) Educational preparation and work experience;

(2) Current licensure, registration or certification;

(3) Written performance evaluations;

(4) Signed contract or letter of appointment specifying conditions of employment;

(5) Record of health examinations.

(c) For persons utilized via contract with another agency, not licensed as a home health care or homemaker-home health aide agency, the primary agency shall maintain records containing at least:

(1) A written verification of compliance with health examination requirements and documentation of clinical competence;

(2) Current licensure, registration or certification of each individual utilized by the primary agency;

(3) A resume of educational preparation and work experience for each individual utilized by the primary agency;

(4) The contract for services between the agencies.

(d) For persons utilized via contract with another licensed home health care or homemaker-home health aide agency, the primary agency shall obtain, upon request, records on the education, training or related work experience of such persons.

(Amended August 31, 1998)

Sec. 19-13-D72. Patient care policies

(a) **General Program Policies.** An agency shall have written policies governing referrals received, admission of patients to agency services, delivery of such services

and discharge of patients. Such policies shall cover all services provided by the agency, directly or under contract. A copy shall be readily available to patients and staff and shall include but not be limited to:

(1) Conditions of Admission:

(A) An agency shall accept a plan of treatment from a chiropractor for services within the scope of chiropractic practice as defined in Connecticut General Statutes Sec. 20-28, and an agency shall accept a plan of treatment from a podiatrist for service within the scope of podiatry practice as defined in Connecticut General Statutes Sec. 20-50. The agency shall have policies governing delivery of these services. Said policies shall conform to all applicable sections of these regulations;

(B) A home assessment by the primary care nurse or, when delegated by the supervisor of clinical services, by other professional staff, to determine that the patient can be cared for safely in the home;

(C) The scope of agency, patient and, when appropriate, family and/or other participation in the home health services to be provided;

(D) Circumstances which render a patient ineligible for agency services, including but not limited to level of care needs which make care at home unsafe, kinds of treatments agency will not accept, payment policy and limitations on condition of admission, if any;

(E) Plan for referral of patients not accepted for care;

(F) Any delay in the start of service shall require prior notification to the patient. Such notification shall include the anticipated start of service date and the agency's plan while the patient is on the waiting list;

(G) The policies define agency responsibility, plan and procedures to be followed to assure patient safety in the event patient services are interrupted for any reason.

(2) Delivery of Services:

(A) Review of Patient Care Plans;

(B) Case management and monitoring at regular intervals based upon the patient's condition, but at least every sixty (60) days. The patient, family, physician or dentist and all agency staff serving the patient shall participate in case management;

(C) Summary reports to patient's physician or dentist of skilled services provided to patient, which shall be forwarded within ten (10) days of admission and at least every sixty (60) days thereafter;

(D) Coordination of agency services with all other facilities or agencies actively involved in patient's care;

(E) Referral to appropriate agencies or sources of service for patients who have need of care not provided by the agency;

(F) Emergency plan and procedures to be followed to assure patient safety in the event agency services are disrupted due to civil or natural disturbances, e.g., hurricanes, snowstorms, etc.

(3) Discharge from Service:

(A) Agency policies shall define categories for discharge of patients. These categories shall include but not be limited to:

(i) Routine discharge - termination of service(s) when goals of care have been met and patient no longer requires home health care services;

(ii) Emergency discharge - termination of service(s) due to the presence of safety issues which place the patient and/or agency staff in immediate jeopardy and prevent the agency from delivering home health care services;

(iii) Premature discharge - termination of service(s) when goals of care have not been met and patient continues to require home health care services;

(iv) Financial discharge - termination of service(s) when the patient's insurance benefits and/or financial resources have been exhausted.

(B) In the case of a routine discharge the agency shall provide:

(i) pre-discharge planning by the primary care nurse, attending physician, or dentist and other agency staff involved in patient's care, which shall be documented in patient's clinical record;

(ii) A procedure through which the patient's physician or dentist is notified each time one or more services are terminated, and when the patient is discharged.

(C) In the case of an emergency discharge the agency shall immediately take all measures deemed appropriate to the situation to ensure patient safety. In addition, the agency shall immediately notify the patient, the patient's physician, and any other persons or agencies involved in the provision of home health care services. Written notification of action taken, including date and reason for emergency discharge, shall be forwarded to the patient and/or family, patient's physician, and any other agencies involved in the provision of home health care services within five (5) calendar days.

(D) In the case of a premature discharge the agency shall document that prior to the decision to discharge a case review was conducted which included patient care staff, supervisory and administrative staff, patient's physician, patient and/or patient representative, and representation from any other agencies involved in the plan of care.

(i) Decision to continue service:

If the decision of the case review is to continue to provide service, a written agreement shall be developed between the agency and the patient or his/her representative to identify the responsibilities of both in the continued delivery of care for the patient. This agreement shall be signed by the agency administrator and the patient or his representative. A copy shall be placed in the patient's clinical record with copies sent to the patient and his or her physician.

(ii) Decision to discharge from service:

If the case review results in an administrative decision to discharge the patient from agency services, the administrator shall notify the patient and/or family and the patient's physician that services shall be discontinued in ten (10) days and the patient shall be discharged from the agency. Services shall continue in accordance with the patient's plan of care to ensure patient safety until the effective day of discharge. The agency shall inform the patient of other resources available to provide health care services.

(E) In the case of a financial discharge the agency shall conduct a:

(i) Pre-termination Review: Whenever one or more home health services are to be terminated because of exhaustion of insurance benefits or financial resources, at least ten (10) days prior to such termination there shall be a review of need for continuing home health care by the patient, his family, the supervisor of clinical services, the patient's physician or dentist, primary care nurse and other staff involved in the patient's care. This determination and, when indicated, the plan developed for continuing care shall be documented in the patient's clinical record.

(ii) Post-termination Review: The clinical records of each patient discharged because of exhaustion of insurance benefits or financial resources shall be reviewed by the professional advisory committee or the clinical record review committee at the next regularly scheduled meeting following the discharge. The committee reviewing the record shall ensure that adequate post-discharge plans have been made for any patient with continuing home health care needs.

(b) Patient Care Standards:

(1) Infusion therapy may be provided to patients of a home health care agency provided services exclude the administration of blood and blood products and a program to monitor the effectiveness and safety of the infusion therapy is developed and implemented.

(A) Definitions

(i) “Infusion therapy” means intravenous, subcutaneous, intraperitoneal, epidural or intrathecal administration of medications, or solutions excluding blood or blood products.

(ii) “Care partner” means a person who demonstrates the ability and willingness to learn maintenance of infusion therapy and who, if not residing with the patient, is readily available to the patient on a twenty four (24) hour basis.

(B) Licensed registered nursing staff who are trained to perform infusion therapy shall be responsible for:

(i) Insertion or removal of a peripherally inserted central catheter (picc), upon the written order of a physician, provided the registered nurse has had appropriate training and experience in such procedures; and

(ii) Delivering of infusion therapy via existing epidural, intraperitoneal and intrathecal lines, monitoring, care of access site and recording of pertinent events and observations in the patient’s clinical record.

(C) Licensed nursing staff trained in infusion therapy shall be responsible for:

(i) Performing a venipuncture for the delivery of intravenous fluids via a needle or intracath;

(ii) Withdrawal of blood from applicable infusion mechanisms for laboratory analysis; and

(iii) Delivering intravenous therapy via existing lines, monitoring, care of access site and recording pertinent events and observations in the patient’s clinical record.

(D) Only a physician shall insert and remove central venous lines, epidural, intraperitoneal and intrathecal lines except as permitted in section (b) (1) (B) (i).

(E) A program to monitor the effectiveness and safety of the agency’s infusion therapy services shall be developed, implemented and monitored.

(F) Infusion therapy services shall be provided in accordance with agency protocol, and practitioners orders and current standards of professional practice.

(G) Policies and procedures for infusion therapy shall be developed and implemented to address:

(i) Timely initiation and administration of infusion therapy;

(ii) Scope of infusion therapy services, therapeutic agents, staff credentials and training necessary to perform infusion therapy;

(iii) Training of patient or care partner to perform infusion therapy;

(iv) Infusion therapy orders, which shall include, type of access, drug, dosage, rate and duration of therapy, frequency of administration, type and amount of solution;

(v) Documentation of infusion therapy services in the patient’s clinical record; and

(vi) Adverse reactions and side effects of infusion therapy.

(H) Current reference materials shall be available for staff relevant to infusion therapy services rendered by the agency.

(2) Hospice services delivered in a patient’s home may be provided only by a home health care agency licensed pursuant to Section 19a-491 of the Connecticut General Statutes, with the approval of the Commissioner of Public Health. An agency shall make application for the provision of hospice services on forms provided by the Department of Public Health. Prior to the provision of hospice services, the

Commissioner shall approve an agency to provide these services, if the agency meets all of the requirements of this subdivision, and shall note this approval on the license of the home health care agency.

(A) Definitions

As used in Section 19-13-D72(b)(2) of the Regulations of Connecticut State Agencies:

(i) “Attending Physician” means a doctor of medicine or osteopathy, licensed pursuant to Chapter 370 or 371 of the Connecticut General Statutes, or licensed in a state which borders Connecticut, who is identified by the patient at the time of selection of hospice care as having the most significant role in the determination and delivery of the patient’s medical care;

(ii) “Bereavement Counselor” means a person qualified through education and experience to counsel patients and family members on issues relating to loss and grief. The hospice program shall define the qualifications necessary to address the unique needs of each population served;

(iii) “Primary Caregiver” means a person who provides care for the patient and who, if not residing with the patient, is readily available to assure the patient’s safety;

(iv) “Case Management” means the coordination and supervision of all hospice care and services, to include periodic review and revision of the patient’s plan of care and services, based on ongoing assessments of the patient’s needs;

(v) “Coordination of Inpatient Care Agreement” means an agreement between the agency and a contractor, which may include an inpatient setting or other health care professionals, for the provision of services during an inpatient admission by the contractor and which includes, but is not limited to, mechanisms for collaboration and coordination of care and sharing of information to meet the ongoing needs of the patient family;

(vi) “Counseling Services” means medical social work, bereavement, spiritual, dietary and other counseling services as required in the plan of care;

(vii) “Family” means group of two or more individuals related by blood, legal status, or affection who consider themselves a family;

(viii) “Home” means the place where a hospice patient resides and may include but is not limited to a private home, nursing home, or specialized residence which provides supportive services;

(ix) “Hospice Employee” means a paid or unpaid staff member of the hospice program;

(x) “Hospice Interdisciplinary Team” means a specifically trained group of professionals licensed pursuant to Title 20 of the Connecticut General Statutes, and volunteers, including but not limited to a physician, a registered nurse, a consulting pharmacist and one or more of the following: a social worker, a spiritual, bereavement or other counselor, the volunteer coordinator, a volunteer with a role in the patient’s plan of care, who work together to meet the physiological, psychological, social, and spiritual needs of hospice patients and their families;

(xi) “Hospice Program” means a program of the home health care agency that is the primary agency engaged in coordinating the provision of care and services to patients who are terminally ill from the time of admission to the hospice program throughout the course of the illness until death or discharge;

(xii) “Inpatient setting” means an institution; licensed in the state in which it is located, which includes a short-term hospital, general, a chronic and convalescent nursing home, or a short-term hospital, special, hospice. A rest home with nursing supervision may also be included for the provision of respite care only;

(xiii) “Medical Director” means a doctor of medicine or osteopathy, licensed pursuant to Chapter 370 or 371 of the Connecticut General Statutes, or licensed in a state which borders Connecticut, who assumes overall responsibility for the medical component of the hospice’s patient care program and who is an employee of the hospice program;

(xiv) “Palliative Care” means treatment which enhances comfort and improves the quality of a patient’s life;

(xv) “Patient Family” means the hospice patient, his or her family members or primary caregivers; the patient family is considered to be a unit and the recipients of hospice care;

(xvi) “Pharmaceutical Services” means pharmacy services provided directly or by contract to patients, primarily for the relief of pain and other symptoms related to the terminal illness, and consultation to the hospice interdisciplinary team;

(xvii) “Plan of Care” means a written, individualized plan of care developed for a hospice patient, in accordance with the wishes of the patient, with the participation of the patient family, attending physician, medical director and members of the hospice interdisciplinary team as appropriate;

(xviii) “Qualified Dietitian” means a dietitian who is registered by the Commission on Dietetic Registration or certified as a dietitian-nutritionist by the Department pursuant to Chapter 384b of the Connecticut General Statutes;

(xix) “Spiritual” means those aspects of a human being associated with the emotions and feelings, which are unique to each individual, as distinguished from the physical body;

(xx) “Spiritual Counselor” means a person who is qualified through education and experience to provide spiritual counseling and support. The hospice program shall define the qualifications necessary to address the unique needs of each population served;

(xxi) “Terminally Ill” means having a diagnosis of advanced irreversible disease, as attested to by a licensed physician;

(xxii) “Volunteer” means an unpaid associate of the hospice program who has successfully completed a training program in preparation for providing assistance to hospice patient families and assisting in the administrative activities of the hospice;

(xxiii) “Volunteer Coordinator” means an employee of the hospice program who has demonstrated skills in organizing, communicating with and managing people.

(B) An agency shall develop and implement written policies and procedures for all hospice services provided which include:

(i) A description of the objectives and scope of each service to be provided, both directly and by contract which assures the continuity of care from the time of admission to the hospice program throughout the course of the patient’s illness until death or discharge. Such services shall include coordination of inpatient care agreements for care as needed in inpatient settings;

(ii) Admission criteria for accepting a patient family for hospice services which includes, but is not limited to, a statement of a physician’s or the medical director’s clinical judgment regarding the normal course of the individual’s illness and a requirement that patients will not be discharged from the hospice program solely as a result of admission to an inpatient setting with which the hospice program has a coordination of inpatient care agreement;

(iii) Procedures for the provision of care and services to the patient family including advising the patient or legal representative of the nature of the palliative care offered. Palliative care includes pain control, symptom management, quality of life

enhancement and spiritual and emotional comfort for patients and their caregivers; the patient's needs are continuously assessed and all treatment options are explored and evaluated in the context of the patient's values and symptoms;

(iv) Qualifications for all providers of care and services in accordance with State law and regulations;

(v) Availability of services;

(vi) Orientation and training for all providers of care and services to the hospice philosophy of patient care. The hospice program shall be responsible for educating all unlicensed personnel assigned to provide services to hospice patient families regarding hospice goals, philosophy and approaches to care;

(vii) For hospice employees, six hours of the annual in-service education requirements in accordance with Section 19-13-D71(a)(2) of these regulations shall address topics related to hospice care. The agency shall ensure, as part of its coordination of inpatient care agreement with an inpatient setting, that all direct service staff receive in-service education including two hours specific to hospice care. The in-service education shall include current information regarding drugs and treatments, specific service procedures and techniques, pain and symptom management, psychosocial and spiritual aspects of care, interdisciplinary team approach to care, bereavement care, acceptable professional standards, and criteria and classification of clients served;

(viii) The procedure for the disposal of controlled drugs maintained in the patient's home by the family or primary caregiver, when those drugs are no longer needed by the patient, in accordance with accepted safety standards.

(C) A hospice program shall have a written quality improvement plan and program which guides the hospice program toward improving organizational performance and achieving the desired outcomes for patient families.

(D) In addition to the membership requirements set forth in Section 19-13-D68(c) of these regulations, a hospice program shall appoint a pharmacist, a volunteer and members of other professional disciplines as appropriate to the agency's Professional Advisory Committee.

(E) The hospice interdisciplinary team shall be composed of individuals who have clinical experience and education appropriate to the needs of the terminally ill and their families. The team shall include:

(i) The medical director, or physician designee;

(ii) A registered nurse, licensed pursuant to Chapter 378 of the Connecticut General Statutes;

(iii) A consulting pharmacist, licensed pursuant to Chapter 400j of the Connecticut General Statutes;

(iv) and one or more of the following, based on the needs of the patient:

I. A social worker, licensed pursuant to Chapter 383b of the Connecticut General Statutes;

II. A bereavement counselor;

III. A spiritual counselor;

IV. A volunteer coordinator;

V. A trained volunteer who is assigned a role in the patient's plan of care;

VI. A physical therapist, occupational therapist or speech-language pathologist.

(F) Interdisciplinary team members shall participate, to the extent of the scope of services provided to a patient family, in:

(i) The admission process and initial assessment for services;

(ii) The development of initial patient family plan of care, within 48 hours of admission;

(iii) Ongoing case management.

(G) The plan of care shall be individualized and interdisciplinary, addressing the patient family. The plan for each service provided to the patient family shall include, but not be limited to, assessment of patient family needs as they relate to hospice services, goals of hospice management, plans for palliative intervention, bereavement care and identification of advance directives.

(i) The hospice program shall assure coordination and continuity of the plan of care, 24 hours per day, seven days per week from the time of admission to the hospice program throughout the course of the patient's illness until death or discharge. A copy of the plan of care shall be furnished to providers in inpatient or other settings where the patient may be temporarily placed and shall include the inpatient services to be furnished;

(ii) The hospice supervisor of clinical services shall be responsible for coordination and management of all services, including those provided directly and by contract, to hospice patient families;

(iii) The plan of care for all hospice services shall be reviewed and revised by members of the interdisciplinary team as often as the patient's condition indicates, but no less frequently than every 14 days.

(H) Assessments and plans of care shall be documented and retained in the clinical record. The clinical record shall also include progress notes from each involved discipline.

(I) Case management shall be implemented based on the patient's condition, but occur no less frequently than every 14 days, and shall include the participation of the patient, family, physician and all members of the interdisciplinary team who are serving the patient family.

(J) There shall be a full-time hospice program director, appointed by the governing authority of the home health care agency, who shall have responsibility to plan, staff, direct and implement the hospice program. The hospice program director shall either:

(i) Be qualified in accordance with Section 19-13-D67(a) of the Regulations of Connecticut State Agencies, but with hospice or home health care supervisory or administrative experience which included care of the sick, in lieu of experience in a health care facility or program; or

(ii) Possess a master's degree in social work and at least one year of supervisory or administrative experience in a hospice or home health care agency.

(K) An agency offering a hospice program shall employ a medical director.

(i) A hospice program medical director shall have a minimum of five years of clinical experience in the practice of medicine or osteopathy.

(ii) The medical director shall be knowledgeable about the psychosocial, spiritual, and medical aspects of hospice care;

(iii) The medical director's responsibilities shall include, but not be limited to:

I. Development and periodic review of the medical policies of the hospice program;

II. Consultation with attending physicians regarding pain and symptom control and medical management as appropriate;

III. Participation in the development of the plan of care for each patient admitted to the hospice;

IV. Serving as a resource for the hospice interdisciplinary team;

V. Acting as a liaison to physicians in the community;

VI. Assuring continuity and coordination of all medical services.

(L) Medical care and direction shall be provided by the patient's attending physician or the hospice medical director. Orders to administer medications shall be written and signed by the patient's attending physician or the hospice medical director.

(M) Nursing services shall be provided by qualified nurses licensed pursuant to Chapter 378 of the Connecticut General Statutes, employed by the hospice program and under the supervision of a primary care nurse.

(i) In addition to the requirements of Section 19-13-D68(e) of these regulations, an agency providing a hospice program shall employ one qualified full-time registered nurse supervisor of clinical services for each ten or fewer, full-time or full-time equivalent professional direct service staff assigned to the hospice program, who shall manage and supervise the day to day activities of the hospice program, including coordination of the interdisciplinary team;

(ii) The supervisor of clinical services assigned to the hospice program may also serve as the hospice program director in programs with six or fewer full-time or full-time equivalent professional direct-services staff.

(iii) A registered nurse, serving as the primary care nurse, shall be responsible for the following:

I. Development and implementation of an individualized, interdisciplinary patient family plan of care;

II. Admission of patients for service and development of the initial patient family plan of care within 48 hours of admission with input from at least one other member of the hospice interdisciplinary team;

III. Coordination of services with the patient family, hospice interdisciplinary team members and all others involved in the plan of care and delivery of patient care services.

(N) Social work services shall be provided by qualified social workers, licensed pursuant to Chapter 383b of the Connecticut General Statutes, employed by the hospice program. The social worker's functions shall include, but not be limited to:

(i) Comprehensive evaluation of the psychosocial status of the patient family as it relates to the patient's illness and environment;

(ii) Counseling of the patient family and primary caregivers;

(iii) Participation in development of the plan of care;

(iv) Participation in ongoing case management with the hospice interdisciplinary team.

(O) Counseling shall include bereavement, spiritual, dietary, and any other counseling services that may be needed by the patient family while enrolled in a hospice program.

(i) Counseling shall be provided only by qualified personnel employed by the hospice;

(ii) Bereavement services shall include:

I. Ongoing assessment of the family and primary caregiver's needs, including the presence of any risk factors associated with the patient's impending death or death and the ability of the family or primary caregiver to cope with the loss;

II. A plan of care for bereavement services which identifies the individualized services to be provided;

III. The availability of pre-death grief counseling for the patient family and primary caregiver;

IV. Ongoing, regular, planned contact with the family and primary caregiver, offered for at least one year after the death of the patient, based on the plan of care;

(iii) A spiritual counselor shall provide counseling, in accordance with the wishes of the patient, based on initial and ongoing assessments of the spiritual needs of the patient family that, at a minimum, include the nature and scope of spiritual concerns or needs. Services may include:

I. Spiritual counseling consistent with patient family beliefs;

II. Communication with and support of involvement by local clergy or spiritual counselor;

III. Consultation and education for the patient family and interdisciplinary team members.

(iv) A qualified dietitian shall provide counseling based on initial and ongoing assessments of the current nutritional status of the patient, pre-existing medical conditions, and special dietary needs. Services may include:

I. Counseling of the patient family and primary caregiver with regard to the patient's diet;

II. Coordination of the plan of care with other providers of nutritional services or counseling.

(P) The hospice program shall have volunteer services available to the hospice patient family. Management of the ongoing active volunteer program including orientation and education, shall be designated in writing to a full-time hospice employee, who may have other responsibilities in addition to those of volunteer coordinator.

(i) Volunteers may be utilized in administrative or direct patient family care roles;

(ii) The hospice program shall provide orientation, ongoing training and supervision of its volunteers consistent with the duties and functions to be performed;

(iii) Volunteers who are qualified to provide professional or homemaker-home health aide services shall meet all standards, licensing or credentialing requirements associated with their discipline.

(Q) The hospice program, which shall serve as the patient's primary agency, may provide services by contract with an agency or individual and shall have legally binding written agreements for the provision of such contracted services in accordance with the requirements of Section 19-13-D70 of the Regulations of Connecticut State Agencies. If a hospice program enters into a coordination of inpatient care agreement with an inpatient setting, the written agreement shall include, but not be limited to, provisions for accommodations for family members to remain with the patient overnight, space for private patient and family visiting, homelike decor, and privacy for the family after a patient's death.

(R) Pharmaceutical services, including consultation with hospice program staff regarding patient needs, shall be made available by the hospice program 24 hours a day, 7 days a week.

(Effective December 28, 1992; amended December 23, 1997, August 31, 1998, December 12, 2001)

Sec. 19-13-D73. Patient care plan

(a) Each medical or dental plan of treatment shall include, but not be limited to:

(1) All diagnoses or conditions, primary and secondary;

(2) Types and frequency of services and equipment required;

(3) Medications and treatments required;

(4) Prognosis, including rehabilitation potential;

(5) Functional limitations and activities permitted;

(6) Therapeutic diet.

(b) The medical or dental plan of treatment shall be reviewed as often as the severity of the patient's condition requires, but at least every sixty (60) days for all

patients receiving one (1) or more skilled services. The original plan and any modifications shall be signed by the patient's physician or dentist within twenty-one (21) days. Agency professional staff shall promptly alert the patient's physician or dentist to any changes in the patient's condition that suggest a need to alter the plan of treatment.

(c) The plan for each service provided the patient and family shall include, but not be limited to:

- (1) Assessment of patient and family needs as they relate to home health services;
- (2) Goals of management, plans for intervention and implementation.

(d) The plan for each agency service shall be reviewed and revised as often as the patient's condition indicates and shall be signed by the primary care nurse and other service personnel at least every sixty (60) days.

(Effective September 20, 1978; amended August 29, 1996)

Sec. 19-13-D74. Administration of medicines

(a) Orders for the administration of medications shall be in writing, signed by the patient's physician or dentist, and in compliance with the agency's written policy and procedure.

(1) Medications shall be administered only as ordered by the patient's physician or dentist and in compliance with the laws of the State of Connecticut;

(2) Orders shall include at least the name of medication, dosage, frequency and method of administration.

(3) All medications shall be administered only by registered nurses or licensed practical nurses licensed in accordance with Chapter 378 of the Connecticut General Statutes or other health care practitioners licensed in this state with statutory authority to administer medications.

(b) Agency staff shall regularly monitor all prescribed and over-the-counter medicines a patient is taking and shall promptly report any problems to the patient's physician or dentist.

(Effective October 26, 1984)

Sec. 19-13-D75. Clinical record system

(a) An agency shall maintain a clinical record system which includes, but not limited to:

(1) A written policy on the protection of records which defines procedures governing the use and removal of records, conditions for release of information contained in the record and which requires authorization in writing by the patient for release of appropriate information not otherwise authorized by law;

(2) A written policy which provides for the retention and storage of records for at least seven (7) years from the date of the last service to the patient and which provides for the retention and storage of such records in the event the agency discontinues operation;

(3) A policy and procedure manual governing the record system and procedures for all agency staff;

(4) Maintaining records on the agency's premises in lockable storage area(s).

(b) A clinical record shall be developed for each patient which shall be filed in an accessible area within the agency and which shall include, but not be limited to:

(1) Identifying data (name, address, date of birth, sex, date of admission or readmission);

(2) Source of referral, including where applicable, name and type of institution from which discharged and date of discharge;

- (3) Patient care plans;
 - (4) Name, address and phone number of physician(s) or dentist(s) responsible for medical or dental care;
 - (5) Pertinent past and current health history;
 - (6) Clinical notes following each patient's contact with the staff members, incorporated no less often than weekly;
 - (7) Progress notes by professional staff and copies of summary or progress reports sent to physician or dentist;
 - (8) Documentation of all case management and monitoring activities, including sixty (60) day utilization review;
 - (9) Discharge summary, if applicable.
 - (c) All notes and reports in the patient's clinical record shall be typewritten or legibly written in ink, dated and signed by the recording person with his full name or first initial and surname and title.
- (Effective September 20, 1978)

Sec. 19-13-D76. Quality assurance program

- (a) An agency shall have a written quality assurance program which shall include but not be limited to the following components:
 - (1) Program evaluation;
 - (2) Quarterly clinical record review;
 - (3) Annual documentation of clinical competence;
 - (4) Annual process and outcome record audits.
- (b) The professional advisory committee or a committee appointed by the governing authority and at least one person from administrative or supervisory staff shall implement, monitor and integrate the various components of the agency's quality assurance program.
 - (c) The committee and staff designated pursuant to regulation 19-13-D76 (b) shall:
 - (1) Annually analyze and summarize, in writing, all findings and recommendations of the quality assurance program;
 - (2) Present written reports of the findings of each component or a written summary report of the findings of the quality assurance program to the professional advisory committee and to the governing authority;
 - (3) Monitor implementation of the recommendations and actions directed by the governing authority based on said report(s);
 - (4) Within one hundred twenty (120) days of action on the report(s) by the governing authority, report in writing to the governing authority, administration and professional advisory committee the progress in implementation of the recommended actions;
 - (5) Ensure that a copy of the annual quality assurance report(s) and the progress report on implementation are maintained by the agency.
 - (d) The program evaluation shall include, but not be limited to:
 - (1) The extent to which the agency's objectives, policies and resources are adequate to maintain programs and services appropriate to community, patient and family needs;
 - (2) The extent to which the agency's administrative practices and patterns for delivery of services achieve efficient and effective community, patient and family services in a five (5) year cycle.
 - (e) At least quarterly, health professionals in active practice, representing at least the scope of the agency's home health care services shall review a sample of active and closed clinical records to assure that agency policies are followed in providing

services. No person involved directly in service to a patient or family shall participate in the review of that patient or family's clinical record.

(1) At least once in each calendar quarter, the agency shall select records for review by a random sampling of all therapeutic cases. The agency's sampling methodology shall be defined in its quality assurance program policies and procedures after approval by the commissioner. The sample of clinical records reviewed each quarter shall be according to the following ratios:

(A) Eighty (80) or less cases; eight (8) records;

(B) Eighty-one (81) or more cases, ten percent (10%) of caseload for the quarter to maximum of twenty-five (25) records. One review form describing the areas to be assessed shall be completed for each record reviewed.

(f) Six (6) months after employment and annually thereafter, a written report shall be prepared on the clinical competence of each direct service staff member employed by or under individual contract to the agency by the employee's professional supervisor, which shall include but not be limited to:

(1) Direct observation of clinical performance;

(2) Patient and family management as recorded in clinical notes and reports prepared by the staff member;

(3) Case management conference performance;

(4) Participation in the agency's inservice education program;

(5) Personal continuing education;

(6) Each staff member shall review and sign a copy of his/her performance evaluation and the agency shall maintain copies of same in the employee's personnel file;

(7) Unsatisfactory performance of direct service staff shall require a plan for corrective action which shall be filed in the employee's personnel folder. In the case of a homemaker-home health aide, the corrective action shall include that the homemaker-home health aide may not perform any task rated as "unsatisfactory" without direct supervision by a registered nurse until after he or she receives training in the task for which he or she was evaluated as "unsatisfactory" and passes a subsequent evaluation with "satisfactory."

(g) **Effective January 1, 1982, an agency shall:**

(1) Include in its quality assurance program annual process and outcome audits of a sample of the clinical records of persons served during the previous twelve (12) months;

(2) Have defined outcome measures for at least two (2) of any diagnostic category representing five (5%) percent or more of its annual caseload. For each successive twelve (12) month period after January 1, 1982, the agency shall expand its outcome measures by one diagnostic category, until measures have been defined for each diagnostic category representing five (5%) percent or more of the agency's caseload; or

(3) Have received approval from the commissioner to use another patient classification system to define outcome measures.

(Effective December 28, 1992)

Sec. 19-13-D77. Administrative organization and records

An agency shall not be eligible for licensure until it demonstrates to the satisfaction of the commissioner that complete authority and control of the agency's operations is vested in a corporation chartered in or properly qualified to do business in this state, or in a person or persons who will reside in this state during the period of licensure. When an agency provides patient care services through more than one

office, the organization, services, control and lines of authority and accountability between the central office and the other office(s) shall be defined in writing the central office, shall be licensed as a home health care agency in compliance with the regulations and standards governing home health care agencies. When patient care services are provided through other offices of the agency, each office shall be in compliance with the regulations and standards, as specified herein, governing supervisor of clinical services, services, patient care policies, patient care plan, administration of medicines, clinical record system, patient bill of rights and responsibilities and facilities. Weekend, holiday, evening or night services may be provided through arrangement with one or more other agencies but there shall be a written description of the organization, services provided, lines of authority, responsibility and accountability between the agencies.

(a) An agency shall be in compliance with all applicable laws and ordinances of the State of Connecticut, the federal government and the town(s) served by the agency.

(b) A copy of the policy and procedure manual shall be available to the staff at all times.

(c) An agency shall submit an annual statistical report of services rendered to the commissioner within ninety (90) days after the close of the agency's fiscal year.

(d) An agency shall provide consumer participation in the annual program evaluation component of the quality assurance program.

(e) An agency shall appoint a pharmacist to its professional advisory committee or to its clinical record review process.

(f) An agency shall provide written information to the actual and potential consumers of its services which accurately describes the services available, the fees for services and any conditions for acceptance or termination of services which may influence a consumer's decision to seek the services of the agency. If a licensed home health care agency is not certified for provision of Medicare home health benefits, its written information shall state this clearly.

(g) Whenever services as defined in C.G.S section 19-576 (d) or (e) are being provided at the same time to the same patient by more than one agency licensed to provide such services, there shall be:

(1) A written contract between participating agencies which meets the requirements of section 19-13-D70 of these regulations; or

(2) A written memo of understanding between the participating agencies or documentation in the patient's clinical record of the plan established between the participating agencies which defines assignment of primary responsibility for the patient's care and methods of communication/coordination between the agencies so that all information necessary to assure safe, coordinated care to the patient is accessible and available to all participating agencies.

(h) Administrative records, including all files, records and reports required by these regulations, shall be maintained on the agency's premises and shall be accessible at any time to the commissioner. These records shall be retained for not less than seven (7) years. There shall be a policy for retention and storage of these records in the event the agency discontinues operation.

(i) An agency shall notify the commissioner immediately of an intent to discontinue operations. In such event, an agency shall continue operations, maintain a staff of administrator, supervisor of clinical services and essential patient care personnel and fulfill all patient care obligations until an orderly transfer of all patients to other sources of care has been completed to the commissioner's satisfaction.

(Effective June 21, 1983)

Sec. 19-13-D78. Patient's bill of rights and responsibilities

An agency shall have a written bill of rights and responsibilities governing agency services which shall be made available and explained to each patient or representative at the time of admission. Such explanation shall be documented in the patient's clinical record. The bill of rights shall include but not be limited to:

(a) A description of available services, unit charges and billing mechanisms. Any changes in such must be given to the patient orally and in writing as soon as possible but no later than thirty (30) working days from the date the agency becomes aware of a change;

(b) Policy on uncompensated care;

(c) Criteria for admission to service and discharge from service;

(d) Information regarding the right to participate in the planning of the care to be furnished, the disciplines that will furnish care, the frequency of visits proposed and any changes in the care to be furnished, the person supervising the patients' care and the manner in which that person may be contacted;

(e) Patient responsibility for participation in the development and implementation of the home health care plan;

(f) Right of the patient or designated representative to be fully informed of patients' health condition, unless contraindicated by a physician in the clinical record;

(g) Right of the patient to have his or her property treated with respect;

(h) Explanation of confidential treatment of all patient information retained in the agency and the requirement for written consent for release of information to persons not otherwise authorized under law to receive it;

(i) Policy regarding patient access to the clinical record;

(j) Explanation of grievance procedure and right to file grievance without discrimination or reprisal from agency regarding treatment or care to be provided or regarding the lack of respect for property by anyone providing agency services;

(k) Procedure for registering complaints with the commissioner and information regarding the availability of the medicare toll-free hotline, including telephone number, hours of operation for receiving complaints or questions about local home health agencies;

(l) Agency's responsibility to investigate complaints made by a patient, patient's family or guardian regarding treatment or care provided or that fails to be provided and lack of respect for the patient's property by anyone providing agency services. Agency complaint log shall include date, nature and resolution of the complaint.

(Effective December 28, 1992)

Sec. 19-13-D79. Facilities

(a) An agency's central office or any offices serving residents of Connecticut shall be located within the State of Connecticut and be accessible to the public.

(b) An agency shall have a communication system adequate to receive requests and referrals for service, maintain verbal contact with health service personnel at all times when they are serving patients, receive calls from patients under the care of the agency and maintain contact as needed with physicians and other providers of care.

(c) The facilities shall provide adequate and safe space for:

(1) Staff to carry out their normal pre and post visit activities;

(2) Supervisory conferences with staff;

(3) Conferencing with patients and their families;

(4) Storage and maintenance of equipment and supplies necessary for patient care;

(5) Maintaining administrative records and files, financial records, and clinical records in file cabinets which can be locked.

(Effective June 21, 1983)

Homemaker-Home Health Aide Agency

Sec. 19-13-D80. Definitions

As used in Sections 19-13-D80 to 19-13-D92 inclusive:

(a) "Agency" means a homemaker-home health aide agency as defined in Section 19a-490 (e) of the Connecticut General Statutes;

(b) "Central office" means the agency office responsible and accountable for all agency operations in this state;

(c) "Clinical experience" means employment in providing patient services in a health care setting;

(d) "Commissioner" means the commissioner of health services, or his/her representative;

(e) "Consumer" means a potential or actual recipient of homemaker-home health aide services;

(f) "Contracted services" or "services under arrangement" means services provided by the agency which are subject to a written agreement with an individual, another agency or facility;

(g) "Contractor" means any organization, individual, home health care or homemaker-home health aide agency that provides services to patients of a primary agency as defined in paragraph (s) of Section 19-13-D80 of these regulations;

(h) "Curriculum" means the plan of classroom and clinical instructions for training and skills assessment as a homemaker-home health aide;

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

(j) "Evening or nighttime service" means service provided between the hours of 5 p.m. and 8 a.m.;

(k) "Full-time" means employed and on duty a minimum of thirty-five (35) hours per workweek;

(l) "Full-time equivalent" means the hours of work by more than one person in a one workweek period which equals a cumulative total which shall not be less than thirty-five (35) hours;

(m) "Holiday service" means service provided on the days specified in the agency's official personnel policies as holidays;

(n) "Homemaker-home health aide" means an unlicensed person who has successfully completed a training and competency evaluation program for the preparation of homemaker-home health aides approved by the department.

(o) "Parent agency" means the agency that develops and maintains administrative control of subdivisions and patient service offices;

(p) "Patient care services" means agency activities carried out by agency staff for or on behalf of a patient. Such services include, but are not limited to, receipt of referral for service, admission to service, assignment of personnel, homemaker-home health aide service, communication/coordination with patient and others involved in the patient's care and development/maintenance of patient's record.

(g) "Patient service office" means one or more separate and distinct offices which provide patient care services and are included under the agency's license. This office shall comply with the regulations of Connecticut State Agencies, Section 19-13-D90;

(r) “Permanent part-time” means employed and on duty a minimum of twenty (20) hours per workweek on a regular basis;

(s) “Primary homemaker-home health aide agency” means the agency that is responsible for the homemaker-home health aide service furnished to patients and for the implementation of the plan of care;

(t) “Professional supervision” means direction and supervision by a registered nurse supervisor, and, as appropriate, a physical therapist supervisor, occupational therapist supervisor, speech therapist supervisor, or social work supervisor;

(u) “Provider agency” means the agency or subdivision that has primary authority and responsibility for provision of services to the patient and family;

(v) “Public health nurse” means a graduate of a baccalaureate degree program in nursing approved by the National League for Nursing for preparation in public health nursing;

(w) “Representative” means a designated member of the patient’s family, or person legally designated to act for the patient in the exercise of the patient’s rights as contained in Sections 19-13-D80 to 19-13-D92 of the Regulations of Connecticut State Agencies.

(x) “Social worker” means a graduate of a master’s degree program in social work accredited by the council on social work education;

(y) “Subdivision” means a unit of a multifunction health care organization which is assigned the primary authority and responsibility for the agency operations. A subdivision shall independently meet the regulations and standards for licensure and shall be independently licensed as a homemaker-home health aide agency;

(z) “Supportive services” means services which include, but are not limited to assistance with personal hygiene, dressing, feeding and incidental household tasks essential to achieving adequate household and family management, and are provided under the supervision of a registered nurse;

(aa) “Weekend service” means services provided on Saturday or Sunday.

(Effective December 28, 1992)

Sec. 19-13-D81. Personnel

(a) An agency administrator shall be a person with one of the following:

(1) A baccalaureate degree in nursing with an active license to practice in this state and at least two (2) years of full-time experience in a homemaker-home health aide agency or related health care facility/program which included care of the sick; or

(2) A baccalaureate degree in social work, home economics, administration, or related human services field with a concentration of study in health services administration, and at least two (2) years of full-time experience in a homemaker-home health aide agency or related health care facility/program which included care of the sick; or

(b) An agency registered nurse supervisor shall be a person with an active license to practice nursing in this state and shall have one of the following:

(1) A baccalaureate degree in nursing and at least two (2) years of full-time clinical experience within the past five (5) years in a home health care agency or related health care facility program which included care of the sick; or

(2) An associate degree in nursing and at least three (3) years of full-time clinical experience in nursing within the past five (5) years, at least two (2) of which were in a home health care agency or related health care facility/program which included care of the sick; or

(3) A diploma in nursing and at least three (3) years of full-time clinical experience in nursing within the past five (5) years, at least two (2) of which were in a home

health care agency or related health care facility/program which included care of the sick.

(c) An agency physical therapist supervisor shall be a person licensed to practice physical therapy in this state and one who has completed a minimum of one (1) year full-time clinical experience in physical therapy;

(d) An agency occupational therapist supervisor shall be a graduate of a basic education program accredited by the American Medical Association for the preparation of occupational therapists, or a person who has successfully completed the national certifying examination and is currently registered by the American Occupational Therapy Association, who has a minimum of one (1) year clinical experience in occupational therapy services and effective July 1, 1979, the occupational therapist supervisor shall be licensed to practice in this state.

(e) An agency social work supervisor shall be a graduate of a master's degree program in social work accredited by the Council on Social Work Education who has a minimum of one (1) year full-time experience in social work.

(Effective December 28, 1992)

Sec. 19-13-D82. General requirements

The agency shall be organized and staffed in compliance with the following:

(a) An agency shall be governed by a governing authority, maintain an active patient care advisory committee, be directed by an administrator and operate any services offered in compliance with these regulations. Compliance with these regulations shall be the joint and several responsibility of the governing authority and the administrator.

(b) Governing Authority:

(1) There shall be a formal governing authority with full legal authority and responsibility for the operation of the agency which shall adopt bylaws or rules that are reviewed and so dated. Such bylaws or rules shall include, but are not limited to:

(A) Purposes of the agency;

(B) Delineation of the powers, duties and voting procedures of the governing authority, its officers and committees;

(C) Qualifications for membership, method of selection and terms of office of members and chairpersons of committees;

(D) A description of the authority delegated to the administrator;

(E) The agency's conflict of interest policy and procedures.

(2) The bylaws or rules shall be available to all members of the governing authority and all individuals to whom authority is delegated.

(3) The governing authority shall:

(A) Meet as frequently as necessary to fulfill its responsibilities as stated in these regulations, but no less than one (1) time per year;

(B) Provide a written agenda and minutes for each meeting;

(C) Provide that minutes reflect the identity of those members in attendance and that, following approval, such minutes be dated and signed by the secretary;

(D) Ensure that the agenda and minutes of any of its meetings or any of its committees are available at any time to the commissioner.

(4) Responsibilities of the governing authority include, but are not limited to:

(A) Services provided by the agency and the quality of care rendered to patients and their families;

(B) Selection and appointment of a patient care advisory committee;

(C) Policy and program determination and delegation of authority to implement policies and programs;

- (D) Appointment of a qualified administrator;
 - (E) Management of the fiscal affairs of the agency;
 - (F) The quality assurance program.
- (5) The governing authority shall ensure that:
- (A) The name and address of each officer and member of the governing authority are reported annually to the commissioner;
 - (B) The name and address of each owner and, if the agency is a corporation, all ownership interests of ten percent (10%) or more (direct or indirect) are reported annually to the commissioner;
 - (C) Any change in ownership is reported to the commissioner within ninety (90) days;
 - (D) The name of the administrator of the agency is forwarded to the commissioner within three (3) days of his/her appointment and notice that the administrator has left for any reason is so forwarded within forty-eight (48) hours.
- (c) **Patient care advisory committee:**
- (1) There shall be a patient care advisory committee, appointed by the governing authority, consisting of at least one (1) physician, one (1) public health nurse, one (1) social worker and two (2) consumers representing the community served by the agency. Professional representatives shall be in active practice in their professions, or shall have been in active practice within the last five (5) years. No member of the patient care advisory committee, shall be an owner, stockholder, employee of the agency or related to same, including by marriage. However, provision may be made for employees to serve on the committee as exofficio members only, without voting powers.
 - (2) The functions of the patient care advisory committee shall be to recommend and review at least annually agency policies on:
 - (A) Scope of service offered;
 - (B) Service policies;
 - (C) Admission and discharge criteria;
 - (D) Professional supervision and care plans;
 - (E) Patient records;
 - (F) Personnel qualifications and training;
 - (G) Quality assurance activities;
 - (H) Patient care issues especially as they relate to the delivery of service and findings of the quality assurance program.
 - (3) The patient care advisory committee shall hold at least two (2) meetings annually.
 - (4) Written minutes shall document dates of meetings, attendance, agenda and recommendations. The minutes shall be presented, read and accepted at the next regular meeting of the governing authority of the agency following the patient care advisory committee meeting. These minutes shall be available at any time to the commissioner.
- (d) **Administrator:**
- (1) There shall be a full-time agency administrator appointed by the governing authority of the agency.
 - (2) The administrator shall have full authority and responsibility delegated by the governing authority to plan, staff, direct and implement the programs and manage the affairs of the agency. The administrator's responsibilities include, but are not limited to:
 - (A) Interpretation and execution of the policies of the governing authority;
 - (B) Program planning, budgeting, management and evaluation based upon community needs and agency resources;

(C) Maintenance of ongoing liaison among governing authority, its committees, the patient care advisory committee and staff;

(D) Employment of qualified personnel, evaluation of staff performance per agency policy, provision of planned orientation and inservice education programs for agency personnel;

(E) Development of a record system and statistical reporting system for program documentation, planning and evaluation, which includes at least the data specified in these regulations;

(F) Preparation of a budget for the approval of the governing authority and implementation of financial policies, accounting system and cost controls;

(G) Assurance of an accurate public information system;

(H) Maintenance of the agency's compliance with licensure regulations and standards;

(I) Distribution of a written plan for the delegation of administrative responsibilities and functions in the absence of the administrator;

(J) Notification to the commissioner, within forty-eight hours, that the registered nurse supervisor is no longer employed by the agency.

(3) An administrator's absence of longer than one month shall be reported to the commissioner.

(e) **Professional Supervision:**

(1) An agency shall employ one (1) full-time registered nurse supervisor for each twenty-five (25) or less full-time or full-time equivalent homemaker-home health aides.

(2) Each homemaker-home health aide shall be assigned to and shall report to the same registered nurse supervisor to ensure clear lines of authority and delegation of patient care.

(3) A registered nurse supervisor shall be accessible by phone and available to make a home visit at all times when homemaker-home health aides are on assignment in a patient's home.

(4) Any absence of the registered nurse supervisor for longer than one month shall be reported to the commissioner. A registered nurse who has at least two (2) years experience in a home health care agency or related health care facility/program, which included care of the sick shall be designated, in writing, to act in any absence of the registered nurse supervisor.

(5) The registered nurse supervisor shall have primary authority and responsibility for maintaining the quality of homemaker-home health aide services provided to the patient. The responsibilities of the registered nurse supervisor shall be clearly delineated in the position description and shall include but not be limited to:

(A) Initial assessment of the patient and home situation and determination that the patient's status and care needs can be safely met by homemaker-home health aide service

(B) Referral of the patient at any time to a home health care agency or other appropriate level of care, when the patient's status and care needs require more than supportive services as defined in 19-13-D80 (z) of these regulations;

(C) Development and periodic review of a written plan of care which shall include the frequency of assessment and methods by which the patient's status and care needs are to be monitored between assessment visits in the home. The plan of care shall be reviewed and revised no less frequently than the plan for the registered nurse supervision of the homemaker-home health aide;

(D) Development and periodic review of the written instructions for the homemaker-home health aide; which shall be completed before the homemaker-home health aide provides any service to the patient. These instructions shall include the scope and limitations of homemaker-home health aide activities, pertinent aspects of patient's condition to be observed and reported to the registered nurse supervisor, and the name and telephone number of the registered nurse supervisor;

(E) Orientation of the homemaker-home health aide in the home, to the patient, family and plan for care;

(F) In situations when the homemaker-home health aide orientation cannot be done in the home prior to initiation of patient care activities, there shall be documentation in the patient's record identifying the circumstances which substantiate that the patient's safety was maintained;

(G) Determination, in the home, that the homemaker-home health aide is competent to carry out all assigned patient care activities;

(H) Visiting and completing an assessment of assigned patients receiving homemaker-home health aide services as often as necessary based on the patient's condition, but not less frequently than every sixty (60) days. The sixty-day assessment shall be completed while the homemaker-home health aide is providing services in the patient's home;

(I) Arranging supervision of a homemaker-home health aide by a physical therapist, occupational therapist, speech therapist or social worker, as appropriate;

(J) Plan for medical or other emergencies.

(K) When appropriate, communication with the patient's source(s) of medical care to secure or report information pertinent to the patient's care;

(L) Development and maintenance of the patient care record;

(M) Coordination of services rendered to the patient and family;

(N) Evaluation of homemaker-home health aide staff, including participation in orientation and inservice education, direct observation of the homemaker-home health aide's performance in patient care situations, review of the records and reports prepared by the homemaker-home health aide, case management conferences with the homemaker-home health aide, and a written performance evaluation of aides not less frequently than six (6) months after date of employment, and annually thereafter;

(O) Consultation with the agency administrator on all aspects of patient care;

(6) When appropriate, the registered nurse supervisor may delegate all or part of the professional supervision to a physical therapist, occupational therapist, speech therapist or social work supervisor. In such situations, the registered nurse supervisor shall review with designated supervisor the patient's plan of care at least every four (4) weeks;

(7) The registered nurse supervisor may also serve as the administrator in agencies with ten (10) or less homemaker-home health aides.

(Effective December 28, 1992; amended June 5, 2007)

Sec. 19-13-D83. Homemaker-home health aide services

(a) An agency shall have written policies governing the delivery of homemaker-home health aide services.

(b) On and after January 1, 1993, no person shall furnish homemaker-home health aide services on behalf of a homemaker-home health aide agency unless such person has successfully completed a training and competency evaluation program approved by the department.

(1) The commissioner shall adopt, and revise as necessary, a homemaker-home health aide training program of not less than seventy-five (75) hours and competency

evaluation program for homemaker-home health aides. The standard curriculum of the training program shall include the following elements which shall be presented in both lecture and clinical settings:

- (A) Communications skills;
- (B) Observation, reporting and documentation of patient status and the care or services furnished;
- (C) Reading and recording temperature, pulse and respiration;
- (D) Basic infection control procedures;
- (E) Basic elements of body function and changes in body function that must be reported to an aide's supervisor;
- (F) Maintenance of a clean, safe and healthy environment;
- (G) Recognizing emergencies and knowledge of emergency procedures;
- (H) The physical, emotional, and developmental needs of and ways to work with the populations served by the homemaker-home health aide agency, including the need for respect for the patient, his or her privacy and his or her property;
- (I) Appropriate and safe techniques in personal hygiene and grooming that include: bath (bed, sponge, tub or shower), shampoo (sink, tub or bed), nail and skin care, oral hygiene, toileting and elimination;
- (J) Safe transfer techniques and ambulation;
- (K) Normal range of motion and positioning;
- (L) Adequate nutrition and fluid intake;
- (M) Any other task that the homemaker-home health aide agency may choose to have the homemaker-home health aide perform.

(2) A trainee's successful completion of training shall be demonstrated by the trainee's performance, satisfactory to the qualified registered nurse designated in subparagraph (9) (A) of this subdivision of the elements required by the curriculum. Each agency that elects to conduct a homemaker-home health aide training program shall submit such information on its homemaker-home health aide training program as the commissioner may require on forms provided by the department. The department may re-evaluate the agency's homemaker-home health aide training program and competency evaluation program for sufficiency at any time.

(3) The commissioner shall adopt, and revise as necessary, a homemaker-home health aide competency evaluation program to include, procedures for determination of competency which may include a standardized test. At a minimum the subject areas listed in subparagraph (1) (C), (I), (J), and (K) of this subdivision shall be evaluated through observation of the homemaker-home health aide's performance of the tasks. The other subject areas in subdivision (1) of this subsection shall be evaluated through written examination, oral examination or observation of a homemaker-home health aide with a patient.

(4) A homemaker-home health aide is not considered competent in any task for which he or she is evaluated as "unsatisfactory." The homemaker-home health aide must not perform that task without direct supervision by a licensed nurse until after he or she receives training in the task for which he or she was evaluated "unsatisfactory" and passes a subsequent evaluation with a "satisfactory" rating.

(5) A homemaker-home health aide is not considered to have successfully passed a competency evaluation if the aide has an "unsatisfactory" rating in more than one of the required subject areas listed in subdivision (1) of this subsection.

(6) The competency evaluation must be performed by a registered nurse who possesses a minimum of two (2) years of nursing experience at least one (1) year of which must be in the provision of home health care.

(7) The state department of education, the board of trustees of community-technical colleges and an adult continuing education program established and maintained under the auspices of the local or regional board of education or regional educational service center and provided by such board or center may offer such training programs and competency evaluation programs in accordance with this subsection as approved by the commissioner

(8) Homemaker-home health aide agencies may offer such training programs and competency evaluation programs in accordance with this subsection provided that they have not been determined to be out of compliance with one (1) or more of the training and competency evaluation requirements of OBRA as amended within any of the twenty-four (24) months before the training is to begin.

(9) Qualifications of homemaker-home health aide training instructors:

(A) The training of homemaker-home health aides must be performed by or under the general supervision of a registered nurse who possesses a minimum of two (2) years of nursing experience, one (1) year of which must be in the provision of home health care.

(B) Qualified personnel from the health field may serve as trainers in the homemaker-home health aide training program under the general supervision of the qualified registered nurse identified in subdivision (9) (A) of this subsection. All trainers shall be licensed, registered and/or certified in their field.

(C) Licensed practical nurses, under the supervision of the qualified registered nurse designated in subdivision (9) (A) of this subsection may serve as trainers in the homemaker-home health aide training program provided the licensed practical nurse has two (2) years of nursing experience, one (1) year of experience which must be in the provision of home health care.

(D) The training of homemaker-home health aides may be performed under the general supervision of the registered nurse supervisor. The registered nurse supervisor is prohibited from performing the actual training of homemaker-home health aides.

(10) Upon satisfactory completion of the training and competency evaluation program the agency or educational facility identified in subdivision (7) of this subsection shall issue documentation of satisfactory completion, signed by the qualified registered nurse designated in subdivision (9) (A) of this subsection, as evidence of said training and competency evaluation. Said documentation shall include a notation as to the agency or educational facility that provided the training and competency evaluation program.

(11) On and after January 1, 1993 any homemaker-home health aide agency that uses homemaker-home health aides from a placement agency or from a nursing pool shall maintain sufficient documentation to demonstrate that the requirements of this subsection are met.

(12) If, since an individual's most recent completion of a training and competency evaluation program or 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 competency evaluation program.

(13) Any person employed as a homemaker-home health aide prior to January 1, 1993, shall be deemed to have completed a training and competency evaluation program pursuant to subsection 19-13-D83 (b) of the regulations of Connecticut State Agencies.

(14) Any person who has successfully completed prior to January 1, 1993 the state-sponsored nurse assistant training program provided through the state depart-

ment of education or through the Connecticut Board of Trustees of community-technical colleges shall be deemed to have completed a homemaker-home health aide training and competency evaluation program approved by the commissioner in accordance with this subsection.

(15) Any person who has completed a nurses aide training and competency evaluation program as defined in section 19-13-D8t (a) of the Regulations of Connecticut State Agencies shall be deemed to have completed a training program as required in this section. Such individual shall complete a homemaker-home health aide competency evaluation before the provision of homemaker-home health aide services.

(16) Any person who has successfully completed a course or courses comprising not less than seventy-five (75) 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 may be deemed to have completed a homemaker-home health 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, such individual shall complete a homemaker-home health aide competency evaluation before the provision of homemaker-home health aide services.

(17) On or after January 1, 1993 a homemaker-home health aide in another state or territory of the United States may be deemed to have completed a training program as required in this subsection provided the homemaker-home health aide agency has sufficient documentation which demonstrates such individual has successfully completed a training program in accordance with subdivision (b) (1). Such individual shall complete a homemaker-home health aide competency evaluation before the provision of homemaker-home health aide services.

(18) The homemaker-home health aide agency shall maintain sufficient documentation to demonstrate that all the requirements of this subsection are met for any individual furnishing homemaker-home health aide services on behalf of the homemaker-home health aide health agency.

(19) Any person who has been deemed to have completed a homemaker-home health aide training program in accordance with this subsection shall be provided with ten (10) hours of orientation by the agency of employment prior to the individual providing any homemaker-home health aide services.

(c) When designated by the supervising registered nurse, duties of the homemaker-home health aide may include:

(1) Assisting the patient with personal care activities; including bathing, oral hygiene, feeding, or dressing;

(2) Assisting the patient with exercises, ambulation, transfer activities and assisting with medications that are ordinarily self-administered;

(3) Performing normal household services essential to health care at home, including shopping, meal preparation, laundry, housecleaning.

(Effective December 28, 1992; amended August 31, 1998)

Sec. 19-13-D84. Contracted services

(a) An agency may hire professional supervision for its homemaker-home health aide staff through contractual arrangements with other agencies or individuals. Supervision provided by the primary agency through arrangements with a contractor agency or individuals shall be set forth in a written contract which clearly specifies:

(1) That the patient's contract for care is with the primary agency;

- (2) The services to be provided by the contractor;
 - (3) The necessity to conform to all applicable primary agency policies, including personnel qualifications, supervisory ratios and staffing patterns;
 - (4) The authority and responsibilities of the supervisor;
 - (5) A term not to exceed one (1) year.
- (Effective September 20, 1978)

Sec. 19-13-D85. Personnel policies

(a) An agency shall have written personnel policies which include but are not limited to:

(1) Orientation policy and procedure. An agency orientation policy for all employees shall include but not be limited to review of the following:

- (A) Agency organization and philosophy of patient care;
- (B) Agency patient care policies and procedures;
- (C) Agency personnel policies and job description;
- (D) Applicable state regulations governing the delivery of homemaker-home health aide services;

(E) Agency's procedure for the documentation of the orientation dates, content and name and title of person providing the orientation;

(2) Inservice education policy and plan which provides an annual average of at least one (1) hour per month for each homemaker-home health aide and a description of the content of each inservice education session. The in-service education program shall be provided by or under the supervision of the registered nurse supervisor;

(3) Performance evaluation, which includes a process for corrective action when an employee receives an unsatisfactory performance evaluation. The corrective action shall include that the homemaker-home health aide may not perform any task rated as "unsatisfactory" without direct supervision by the registered nurse supervisor until after he or she receives training in the task for which he or she was evaluated as "unsatisfactory" and passes a subsequent evaluation with "satisfactory." Each staff member shall review and sign a copy of his/her performance evaluation and the agency shall maintain copies of same in the employee's personnel file;

(4) Position descriptions;

(5) Physical examination, including a tuberculin test and a physician's statement that the employee is free from communicable diseases, must be prior to assignment to patient care activities.

(b) For all employees employed directly or by contracts with individuals, the agency shall maintain individual personnel records containing at least the following:

- (1) Educational preparation and work experience;
- (2) Current licensure, registration or certification;
- (3) Written performance evaluations;
- (4) Signed contract or letter of appointment specifying conditions of employment;
- (5) Record of physical examination;
- (6) Documentation of orientation

(c) For persons utilized via contract with another agency not licensed as a home health care or homemaker-home health aide agency, the primary agency shall maintain records containing at least:

(1) A written verification of compliance with health examination requirements and performance evaluation requirements;

(2) Current licensure, registration or certification of each individual utilized by primary agency;

(3) A resume of educational preparation and work experience for each individual utilized by the primary agency;

(4) The contract for services between the agencies.

(d) For persons utilized via contract with another licensed home health care or homemaker-home health aide agency, the primary agency shall maintain records on the education, training and/or related work experience of such persons.

(Effective December 28, 1992)

Sec. 19-13-D86. Service policies

(a) An agency shall have written policies governing referrals received, admission of patients, delivery of services and discharge of patients. Such policies shall be applicable to services provided by the agency, directly or under arrangement. A copy shall be readily available to patients and staff and shall include but not be limited to:

(1) Conditions of admission:

(A) An assessment of the patient and home shall be completed by the registered nurse supervisor to determine that the patient can be cared for safely in the home by a homemaker-home health aide;

(B) Plan for referral of patients not accepted for care;

(C) Following acceptance of a referral, any delay in the start of service shall require prior notification to the patient. Such notification shall include the anticipated start of service date and the agency's plan while the patient is on the waiting list;

(D) When circumstances require the services of a homemaker-home health aide prior to an assessment of the patient and home by a registered nurse supervisor, the factors necessitating delivery of services prior to an assessment and verification that the patient's safety is assured shall be documented in the patient's record. Such assessment shall be completed within twenty-four (24) hours of the initiation of services;

(E) Establishment of a plan of care;

(F) Definition of the scope of agency, patient and, when appropriate, family responsibilities for the services to be provided;

(G) Circumstances which render a patient ineligible for agency services, including factors which make home care unsafe, the kinds of treatments an agency will not accept, payment policy and limitations or conditions of admission, if any;

(H) The policies define agency responsibility, plan and procedures to be followed to assure patient safety in the event patient services are interrupted for any reason.

(2) Delivery of services:

(A) Frequency and nature of professional registered nurse supervision of patient situation;

(B) Review of original plan of care at least every sixty (60) days, or more often depending on patient's condition;

(C) Coordination of agency services with all other facilities or agencies actively involved in patient's care;

(D) Referral to appropriate agencies or sources of service for patients who have need of care not provided by agency.

(E) Emergency plan and procedures to be followed to assure patient safety in the event agency services are disrupted due to civil or natural disturbances, e.g., as hurricanes, snowstorms, etc.

(3) Discharge from service:

(A) The agency shall have policies and plans which it shall follow for the following discharge categories:

(i) Routine discharge which means termination of services when patient no longer requires homemaker-home health aide service;

(ii) Emergency discharge which means termination of services due to the presence of safety issues which place the patient and/or agency staff in immediate jeopardy and prevent the agency from delivering homemaker-home health aide services;

(iii) Premature discharge which means termination of services when patient continues to require homemaker-home health aide services;

(iv) Financial discharge which means termination of services when the patient's insurance benefits and/or financial resources have been exhausted.

(B) In the case of a routine discharge the agency shall provide:

(i) Pre-discharge planning by the registered nurse supervisor, which shall be documented in patient's record.

(C) In the case of an emergency discharge, the registered nurse supervisor shall immediately take all measures deemed appropriate to the situation to assure patient safety. Written notification of action taken, including date and reason for emergency discharge, shall be forwarded to the patient and/or patient representative, patient's source of medical care as applicable, and any other agencies involved in the provision of home health services within five (5) calendar days.

(D) In the case of a premature discharge, the agency shall document that prior to the decision to discharge, a case review was conducted by the registered nurse supervisor, administrator, patient's source of medical care as applicable, patient and/or patient representative, and representation from any other agencies involved.

(i) Decision to continue service:

If the decision of the case review is to continue to provide service, a written agreement shall be developed between the agency and the patient and/or patient representative to identify the responsibilities of both in the continued delivery of care for the patient. This agreement shall be signed by the agency administrator and the patient and/or patient representative. A copy shall be placed in the patient's record with copies to the patient and/or patient representative.

(ii) Decision to discharge from service:

If the case review results in the decision to discharge the patient from agency services, the administrator shall notify the patient and/or patient representative, and the patient's source of medical care as applicable, and any other agencies involved in the provision of home health services, that services shall be discontinued in ten (10) days and the patient shall be discharged from the agency. Services shall continue in accordance with the patient's plan of care to assure patient safety until the effective day of discharge. The agency shall inform the patient of other resources available to provide homemaker-home health aide services. This discharge notice shall include the patient's right to appeal this decision within the ten (10) day notice of discharge. All patient appeals shall be reviewed by the agency's patient care advisory committee with ten (10) days of receipt of the appeal to advise on the appropriateness of the discharge or to recommend readmission and terms under which agency services will be provided.

(E) In the case of a financial discharge, the agency shall conduct:

(i) Pre-termination Review: Whenever homemaker-home health aide services are terminated because of exhaustion of insurance benefits or financial resources, at least ten (10) days prior to such termination there shall be a review of need for continuing homemaker-home health aide services by the patient, his family and/or patient representative, the registered nurse supervisor, and the patient's source of medical care as applicable, and other staff involved in the patient's care. This

determination and, when indicated, the plan developed for continuing care shall be documented in the patient's record.

(ii) Post-termination Review: The records of each patient discharged because of exhaustion of insurance benefits or financial resources shall be reviewed by the patient care advisory committee at the next regularly scheduled meeting following the discharge. The committee reviewing the record shall ensure that adequate post-discharge plans have been made for each patient with continuing care needs.

(Effective December 28, 1992)

Sec. 19-13-D87. Plan of care

(a) A written plan of care for homemaker-home health aide service shall be completed by the registered nurse supervisor in consultation with the patient, family and others involved in care to the patient, within seven (7) days of the patient's admission for services. The plan shall include, but not be limited to:

- (1) Initial assessment and reassessment frequency;
- (2) Documentation of patient's care needs;
- (3) Goals of management;

(4) Written instructions for the homemaker-home health aide shall be completed before the homemaker-home health aide provides any service to the patient. These instructions shall include the scope and limitations of homemaker-home health aide activities, pertinent aspects of patient's condition to be observed and reported to the registered nurse supervisor, and name and telephone number of the registered nurse supervisor;

- (5) Plan for medical or other emergencies;
- (6) Frequency of review and revision of care plan;
- (7) Frequency of registered nurse supervision;

(8) Plan for registered nurse supervision of the homemaker-home health aide including frequency and methods of insuring ongoing competence.

(Effective December 28, 1992)

Sec. 19-13-D88. Patient records

(a) An agency shall maintain a patient record system which includes, but is not limited to:

(1) A written policy on the protection of records which defines procedures governing the use and removal of records, conditions for release of information contained in the record and which requires authorization in writing by the patient for release of appropriate information not otherwise authorized by law;

(2) A written policy which provides for the retention and storage of records for at least seven (7) years from the date of the last service to the patient and which provides for records retention and storage of such records in the event the agency discontinues operation;

(3) A policy and procedure manual governing the records system and procedures for all agency staff;

(4) Maintaining records on the agency's premises in lockable storage area(s).

(b) A record shall be developed for each patient which shall be filed in an accessible area within the agency and which shall include, but not be limited to:

(1) Identifying data (name, address, date of birth, sex, date of admission or readmission);

(2) Source of referral, including where applicable, name and type of institution from which discharged and date of discharge;

(3) Assessment of the patient and home;

- (4) Plan of care and written instructions for the homemaker-home health aide;
- (5) Name, address and phone number of patient's source of medical care;
- (6) Pertinent past and current health history;
- (7) Documentation of the registered nurse supervisor activities and, when appropriate, other professional supervisor(s) activities related to patient care;
- (8) Documentation of coordination of services with the patient, family and others involved in the plan of care;
- (9) Homemaker-home health aide notes which the registered nurse supervisor shall review, shall be incorporated in the patient's record no less often than every two (2) weeks;
- (10) Discharge summary, if applicable.

(c) All notes and reports in the patient's record shall be typewritten or legibly written in ink, dated and signed by the recording person with his full name, or first initial, surname and title.

(Effective December 28, 1992)

Sec. 19-13-D89. Quality assurance program

(a) An agency shall have a written quality assurance program which shall include but not be limited to:

- (1) Program evaluation;
- (2) Patient record review.

(b) The governing authority, or a committee appointed by the governing authority and the patient care advisory committee shall conduct the program evaluation which shall include, but not be limited to:

(1) The extent to which the agency's objectives, policies and resources are adequate to maintain programs and services appropriate to community, patient and family needs;

(2) The extent to which the agency's administrative practices and patterns for delivery of services achieve efficient and effective community, patient and family services in a five (5) year cycle.

(c) At least quarterly, the professional members of the patient care advisory committee shall review a random sample of active and closed patient records. Each record review shall be documented on a record review form and shall include, but not be limited to verification, that:

(1) Agency policies are followed in the provision of services to patients and families;

(2) Homemaker-home health aide services are utilized appropriately in relation to agency resources and patient or family resources;

(3) Services are provided only to patients whose level of care needs can be safely met by a homemaker-home health aide;

(4) Provision of care is coordinated within the agency and with other agencies involved in the care of the patient or family.

(5) Referral of the patient to a home health care agency when the patient's status and care needs are no longer limited to supportive services.

(d) An agency's sampling methodology shall be defined in its quality assurance program policies and procedures. The sample of patient records reviewed each quarter shall be according to the following ratios:

(1) Eighty (80) or less cases; eight (8) records;

(2) Eighty-one (81) or more cases; ten percent (10%) of caseload for the quarter to maximum of twenty-five (25) records.

(e) An annual written report of the agency's quality assurance program shall summarize all findings and recommendations resulting from the quality assurance activities. This report and documentation of all actions or implementations on the findings or recommendations included in the report shall be available to the commissioner.

(Effective December 28, 1992)

Sec. 19-13-D90. Administrative organization and records

(a) An agency shall not be eligible for licensure until it demonstrates to the satisfaction of the commissioner that complete authority and control of the agency's operations is vested in a corporation chartered in or properly qualified to do business in this state, or in a person or persons who will reside in this state during the period of licensure. When an agency provides services through more than one office, the organization, services, control and lines of authority and accountability between the central office and the other office(s) shall be defined in writing. The central office shall be licensed as a homemaker-home health aide agency in compliance with the regulations and standards governing homemaker-home health aide agencies. When patient care services are provided through other offices of the agency, each office shall be in compliance with the regulations and standards, as specified herein, governing registered nurse supervisor, services, service policies, plan of care, patient records, patient bill of rights and responsibilities, and facilities. Weekend, holiday, evening or night services may be provided through arrangement with one or more other agencies but there shall be a written description of the organization, services provided, lines of authority, responsibility and accountability between the agencies.

(b) Whenever services as defined in C.G.S. Section 19a-490 (d) or (e) are being provided at the same time to the same patient by more than one agency licensed to provide such services, there shall be:

(1) A written contract between the participating agencies which meets the requirements of Section 19-13-D84 of these regulations; or

(2) A written memo of understanding between the participating agencies or documentation in the patient's record of the plan established between the participating agencies which defines assignment of primary responsibility for the patient's care and methods of communication/coordination between the agencies so that all information necessary to assure safe, coordinated care to the patients is accessible and available to all participating agencies.

(c) An agency shall maintain compliance with all applicable laws and ordinances of the State of Connecticut, the federal government and the town(s) served by the agency.

(d) A copy of the policy and procedure manual shall be available to the staff at all times.

(e) An agency shall prepare an annual statistical report on services rendered which shall be submitted to the commissioner within ninety (90) days after the close of the agency's fiscal year.

(f) An agency shall provide written information to the actual and potential consumers of its services which accurately describes the service available, the fees for services and any conditions for acceptance or termination of services which may influence a consumer's decision to seek the services of the agency. The written information shall include that the agency is not certified for provision of medicare home health benefits.

(g) An agency shall provide consumer participation in the annual program evaluation component of the quality assurance program.

(h) Administrative records, including all files, records and reports required by these regulations, shall be maintained on the agency's premises and shall be accessible at any time to the commissioner. These records shall be retained for not less than seven (7) years. There shall be a policy for retention and storage of these records in the event the agency discontinues operation.

(i) An agency shall notify the commissioner immediately of an intent to discontinue operations. In such event, an agency shall continue operations, maintain a staff of administrator, registered nurse supervisor and essential homemaker-home health aide personnel and fulfill all patient care obligations until an orderly transfer of all patients to other sources of care has been completed to the commissioner's satisfaction.

(Effective December 28, 1992)

Sec. 19-13-D91. Patient's bill of rights and responsibilities

An agency shall have a written bill of rights and responsibilities governing agency services which shall be made available and explained to each patient and/or patient representative at the time of admission. Such explanation shall be documented in the patient's record. The Bill of Rights shall include but not be limited to:

(a) A description of available services, unit charges, and billing mechanisms; any changes in such must be given to the patient orally and in writing as soon as possible but no later than fifteen (15) working days from the date the agency becomes aware of a change;

(b) Policy on uncompensated care;

(c) Criteria for admission to service and discharge from service;

(d) Information in advance regarding the right to participate in the planning of the care to be furnished, the frequency of visits proposed and any changes in the care to be furnished, the name of the person supervising the patient's care and the manner in which that person may be contacted;

(e) Patient participation in the implementation of the plan of care;

(f) Right of the patient and/or patient representative to be fully informed of patient's health condition, unless contra-indicated by the patient's source of medical care in the clinical record;

(g) Right of the patient to have his or her property treated with respect;

(h) Explanation of confidential treatment of all patient information retained in the agency and the requirement for written consent for release of information to persons not otherwise authorized under law to receive it;

(i) Policy regarding patient access to the patient record;

(j) Explanation of grievance procedure and right to file grievance without discrimination or reprisal from agency regarding care provided or failed to be provided, or regarding the lack of respect for property by anyone providing agency services;

(k) Agency's responsibility to investigate complaints made by a patient, patient's family or guardian regarding care provided or that fails to be provided and lack of respect for the patient's property by anyone providing agency services. Agency complaint log shall include date, nature and resolution of the complaint;

(l) Procedure for registering complaints with the commissioner.

(Effective December 28, 1992)

Sec. 19-13-D92. Facilities

(a) An agency's central office or any other office(s) serving residents of Connecticut shall be located within the State of Connecticut and be accessible to the public.

(b) An agency shall have a communication system adequate to receive requests and referrals for service, maintain verbal contact with health service personnel at all times when they are serving patients, receive calls from patients under the care of the agency and maintain contact as needed with the patients source of medical care as applicable and other providers of care.

(c) The facilities shall provide adequate and safe space for:

- (1) Staff to carry out their normal pre and post visit activities;
- (2) Supervisory conferences with staff;
- (3) Conferencing with patients and their families;
- (4) Storage and maintenance of equipment and supplies necessary for patient care;
- (5) Maintaining administrative records and files, financial records, and patient records in file cabinets which can be locked.

(Effective December 28, 1992)

Coordination, Assessment and Monitoring Agency Licensure Regulations

Secs. 19-13-D93—19-13-D104.

Repealed, June 30, 1998.

Sec. 19-13-D105. Assisted living services agency

(a) **Definitions.** As used in this section:

- (1) “Agency” means assisted living services agency.
- (2) “Assisted living services” for the purpose of this section only means nursing services and assistance with activities of daily living provided to clients living within a managed residential community having supportive services that encourage clients primarily age fifty-five (55) or older to maintain a maximum level of independence. Routine household services may be provided as assisted living services by the assisted living services agency or by the managed residential community as defined in subsection (a) (13). These services provide an alternative for elderly persons who require some help or aid with activities of daily living as described in subsection (a) (4) or nursing services in order to remain in their private residential units within the managed residential community.
- (3) “Assisted living services agency” means an entity that provides assisted living services.
- (4) “Assisted living aide” means an unlicensed person who has successfully completed a training and competency evaluation program in accordance with Section 19-13-D8t (1), Section 19-13-D69 (d) (2) or Section 19-13-D83 (b) of the regulations of Connecticut State Agencies. An assisted living aide may assist clients with one or more of the following activities of daily living: ambulation, feeding, bathing, dressing, grooming, toileting, oral hygiene, transfers, exercise and supervision of self administration of medications.
- (5) “Client” means the recipient of the assisted living services provided by licensed nurses or assisted living aides.
- (6) “Client service program” means a written schedule of assisted living services to be provided to, reviewed with and agreed to by a client or client representative.
- (7) “Commissioner” means the Commissioner of the Department of Public Health and Addiction Services, or the commissioner’s representative.
- (8) “Community” means managed residential community.
- (9) “Core services” means the services described in subsection (c) (3) of this section which shall be made available in order for an assisted living services agency,

for the purpose of this section only, to provide services within a managed residential community.

(10) “Department” means the Connecticut Department of Public Health and Addiction Services.

(11) “Full time” means on duty a minimum of thirty-five (35) hours per workweek.

(12) “Licensed nurse” means a registered nurse or licensed practical nurse licensed under chapter 378 of the Connecticut General Statutes.

(13) “Managed residential community” means a facility consisting of private residential units that provides a managed group living environment, including housing and services primarily for persons age fifty-five (55) or older.

(14) “Primary agency” means an assisted living services agency that contracts for the services of other organizations, agencies or individuals who provide care or services to its clients.

(15) “Private residential unit” means a living environment belonging to a tenant(s) that includes a full bathroom within the unit including a water closet, lavatory, tub or shower bathing unit and access to facilities and equipment for the preparation and storage of food.

(16) “Self administration of medications” means a client taking medication in accordance with directions for use and includes:

(A) the client removing an individual dose from a container of medications that have been ordered by a physician or health care practitioner with the statutory authority to prescribe medications and dispensed by a pharmacy or purchased over-the-counter by or under the direction of the client; or

(B) the client taking an individual or multiple dose(s) of medications that have been prepared or prepped by a licensed nurse, family member or significant other and stored for client administration in the client’s home.

(17) “Tenant” means a person who either owns, rents under a lease agreement or otherwise contracts for the use of the home within a managed residential community in which that person resides.

(b) Assisted living services agency

(1) If it is determined by the appropriate state agency that a certificate of need is required to operate an assisted living services agency, the certificate of need shall be a prerequisite to licensing.

(2) Application for licensure

(A) No person shall operate an assisted living services agency without a license issued by the department in accordance with Connecticut General Statutes, Section 19a-491.

(B) Application for the grant or renewal of a license to operate an assisted living services agency shall be made to the department, in writing, on forms provided by the department; shall be signed by the person seeking authority to operate the service; shall be notarized; and shall include, but not necessarily be limited to, the following information:

(i) a list of the managed residential communities where assisted living services shall be provided;

(ii) an affidavit attesting that assisted living services shall be provided only at managed residential communities that have complied with the requirements of subsection (c) of this section;

(iii) an affidavit attesting that assisted living services shall be provided on an individual basis to clients who fully understand and agree to the provision of services and are made aware of the costs involved prior to the initiation of such services;

- (iv) the total number of employees, by category;
- (v) the services provided;
- (vi) evidence of financial viability to include a projected two (2) year budget, with estimates of net income and expenditures, at the time of initial application;
- (vii) a certificate of malpractice and public liability insurance;
- (viii) a certificate of good standing, if applicable;
- (ix) a statement of ownership and operation, to include, but not necessarily be limited to the following information:

(a) the name and address of each owner and, if the agency is a corporation, all ownership interests (direct or indirect) of ten percent (10%) or more; and

(b) the name and address of each officer, director and member of the governing authority;

(x) any relevant statistical information requested by the department;

(xi) the agent for service; and

(xii) a listing of the health care institutions or agencies owned or operated in other states, at the time of initial application.

(C) The assisted living services agency shall notify the department of any changes in the information provided in accordance with subparagraph (B)(i)(v)(vii)(viii)(ix) and (xi) of this subdivision.

(3) Issuance and renewal of license

(A) Upon determination by the department that the assisted living services agency is in compliance with chapter 368V of the Connecticut General Statutes and the regulations thereunder pertaining to its licensure, the department shall issue a license or renewal of license to operate the service for a period not to exceed two (2) years.

(B) Application for license renewal shall be made in accordance with subdivision (2)(B) of this subsection not less than thirty (30) days preceding the date of expiration of the agency's current license.

(C) A license shall be issued in the name of the entity that has submitted application for the license.

(D) The license shall not be transferable to any other person, entity or service.

(E) Each license shall list on its face, the name of the licensee, the "doing business as" name, the location(s) served and the date of issuance and expiration.

(F) The license shall be posted in the business office of the licensee.

(G) The licensee shall immediately notify the department in writing of any change in the supervisor of the assisted living services agency.

(H) Any change in the ownership of an assisted living services agency, owned by an individual, partnership or association or the change in ownership or beneficial ownership of ten percent (10%) more of the stock of a corporation that owns, conducts, operates or maintains such agency, shall be subject to prior approval of the department. The licensee shall notify the department in writing of any such proposed change of ownership, at least ninety (90) days prior to the effective date of the proposed change.

(4) Suspension, revocation, denial, non-renewal or voluntary surrender of license.

(A) A license may be suspended, revoked, denied or its renewal refused whenever in the judgment of the department the facility:

(i) fails to comply with applicable regulations prescribed by the commissioner or statutes;

(ii) furnishes or makes any false or misleading statements to the department in order to obtain or retain the license; or

(iii) provides assisted living services in a managed residential community that fails to provide or arrange to make available the core services on a regular and continual basis.

(B) In the event of the suspension, revocation, denial or non-renewal of a license, the assisted living services agency shall have the opportunity for a hearing in accordance with the contested case provisions of Chapter 54 of the Connecticut General Statutes and Sections 19a-4-1 through 19a-4-31 of the regulations of Connecticut State Agencies, as applicable.

(C) Refusal to grant the department access to clients, records and staff of the agency shall be grounds for suspension, revocation, denial or non-renewal of the license.

(D) Surrender of license. The licensee shall notify, in writing, each client receiving services from the agency, the next of kin or legal representative, and any third party payors concerned, at least thirty (30) days prior to the voluntary surrender of an assisted living services agency license or surrender of license upon the department's order of revocation, refusal to renew, or suspension of license. Arrangements shall be made by the licensee for the continuation of care and services as required for any individual client following the surrender of the agency's license. This notice shall include at a minimum:

(i) a statement by the assisted living services agency identifying which services shall no longer be provided to clients; and

(ii) information regarding other resources available to provide health care services to clients.

(5) The assisted living services agency shall ensure that all of the core services are provided. In the event that a managed residential community fails to provide or arrange to make available one or more of the core services on a regular and continual basis, the licensee shall terminate the provision of assisted living services to the managed residential community. The department, each client receiving services from the agency, the next of kin or legal representative and any third party payors concerned shall be mailed written notice from the licensee at least thirty (30) days prior to the termination of services. Arrangements shall be made by the licensee for the continuation of care and services as required by any individual client following termination of the assisted living service. In the event that the disruption of services is temporary, alternative arrangements for the health and safety of the clients shall be made immediately by the managed residential community, with full service restored in not more than seven (7) days.

(6) The assisted living services agency shall maintain records of all temporary service disruptions or the managed residential community's failure to provide core services and shall record the length of disruptions and provision of alternative arrangements.

(7) Waiver

(a) The commissioner in accordance with section 19a-6c of the Connecticut General Statutes, may waive provisions of this section for assisted living services agencies, only when such agencies provide services in state-funded congregate housing facilities. No waiver of this section shall be made if the commissioner determines that the waiver would:

(i) endanger the life, safety or health of any resident receiving assisted living services in a state-funded congregate housing facility;

(ii) impact the quality or provision of services provided to a resident in a state-funded congregate housing facility;

(iii) revise or eliminate the requirements for an assisted living services agency's quality assurance program;

(iv) revise or eliminate the requirements for an assisted living services agency's grievance and appeals process; or

(v) revise or eliminate the assisted living services agency's requirements relative to a client's bill of rights and responsibilities.

(B) The commissioner, upon the granting or renewing of a waiver of any provision of this section, may impose conditions, which assure the health, safety, and welfare of residents receiving assisted living services in a state-funded congregate housing facility. The commissioner may revoke such waiver upon a finding:

(i) that the health, safety, or welfare of any patient has been jeopardized; or

(ii) that such facility or agency has failed to comply with such conditions as the commissioner may impose pursuant to this subparagraph.

(C) Any agency requesting a waiver shall apply in writing to the department. Such application shall include:

(i) the specific regulations for assisted living service agencies for which the waiver is requested;

(ii) reasons for requesting a waiver, including a statement of the type and degree of any hardship that would result to the agency upon enforcement of the regulations;

(iii) the specific relief requested;

(iv) reasons that the waiver would not endanger the life, safety or health of any resident or negatively impact the quality or provision of services to residents; and

(v) any documentation which supports the application for waiver.

(D) Waiver applications shall be signed by a person authorized to bind the agency and shall be notarized.

(E) In consideration of any application for waiver, the commissioner shall consider the following:

(i) the maximum resident capacity;

(ii) the impact of a waiver on care provided; and

(iii) alternative policies or procedures proposed.

(F) Waivers shall be granted for a period of no more than two (2) years. An agency shall reapply in writing to the department in order to renew such waiver at least sixty (60) days in advance of the expiration date of the current waiver.

(G) If the commissioner, upon the granting of a waiver, imposes any conditions to ensure the health, safety and welfare of residents, the agency shall acknowledge in writing his or her agreement to abide by such conditions.

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

(c) Managed residential communities served by assisted living services agencies

(1) Assisted living services may not be provided in a managed residential community unless the managed residential community has notified the department either in writing or by telephone of its intention to provide or arrange to make available licensed assisted living services and has submitted all information as required in this subsection and until the assisted living services agency has been issued a license to operate by the department. The information shall be provided to the department on forms provided by the department, shall be signed by the owner(s) or the operating or managing entity and shall be notarized. The form(s) shall include the following information:

(A) evidence of compliance with local zoning ordinances, local building codes and the Connecticut Fire Safety Code and Supplement;

(B) name of the management company or manager, as appropriate;

(C) legal entity that owns or operates the managed residential community;

(D) description of the manner in which tenants are advised that the managed residential community is not licensed by the department;

(E) description of the information provided to tenants informing them of the assisted living services and home health care services available for individual use and how to access itemized costs of services delivered by these providers;

(F) person to whom official notices are to be sent;

(G) name of the assisted living services agencies; and

(H) attestation that the core services described in subdivision (3) of this subsection are made available and are accessible on a regular and continual basis to those tenants who choose to use such core services.

(2) Upon receipt of the form(s) by the department, the department shall notify the managed residential community in writing within thirty (30) days that either the managed residential community's form(s) is complete and shall be maintained on file in the department or that the information submitted was incorrect or incomplete.

(3) A managed residential community shall provide or arrange to make available the following core services to its tenants who choose to use any or all of the core services:

(A) regularly scheduled meal service for three (3) meals per day;

(B) regularly scheduled laundry service for personal laundry and linens;

(C) regularly scheduled transportation for personal shopping, social and recreational events, health care appointments and similar needs and for which public bus transportation shall not qualify as the only form of transportation;

(D) regularly scheduled housekeeping services;

(E) maintenance service for tenants' living units, including chore services for routine domestic tasks that the tenant is unable to perform; and

(F) programs of social and recreational opportunities.

(4) A managed residential community shall also provide:

(A) a formally established program that provides tenants with twenty-four (24) hour a day security designed to protect tenants from intruders;

(B) an emergency call system in each living unit;

(C) on-site washers and dryers sufficient to meet the needs of the tenants; and

(D) common use space that is sufficient in size to accommodate fifty percent (50%) of the tenant population.

(5) The managed residential community shall employ an on-site service coordinator who reports directly to the operating or managing entity or the administrator of the managed residential community.

(A) The service coordinator shall possess at a minimum a bachelor's degree in social work or in a related human service field. Individuals without a bachelor's degree may be hired if they have an associate's degree in social work or in a related human service field and two (2) years of experience in a social service delivery system dealing with issues and coordinating services related to persons primarily age fifty-five (55) or older. Individuals without a bachelor's degree or an associate's degree may be hired if they have four (4) years of experience in a social service delivery system dealing with issues and coordinating services related to persons primarily age fifty-five (55) or older. The service coordinator should have prior supervisory or management experience. Any person employed as a service coordina-

tor prior to December 1, 1994 shall be eligible to continue in the facility of employment without restriction.

(B) Responsibilities of the service coordinator shall include, but not necessarily be limited to:

(i) ensuring that the services required by this subsection are provided or made available to all tenants;

(ii) assisting tenants in making arrangements to meet their personal needs;

(iii) establishing collaborative relations with provider agencies, support services and community resources.

(iv) establishing a tenant council, ensuring that a private space is provided to the group for meetings and providing assistance and responding to written requests that result from group meetings;

(v) serving as an ongoing liaison with the assisted living services agencies to include liaison with the assisted living services agencies' quality assurance committee as required in subsection (I) of this section;

(vi) ensuring that a tenant information system is in place; and

(vii) developing a written plan for the delegation of responsibilities and functions in the absence of the service coordinator.

(C) A service coordinator's absence of longer than one (1) month shall be reported to any assisted living services agencies servicing the community.

(6) The managed residential community, through its service coordinator or any other representative, may not provide health services, including but not limited to the provision of rehabilitative therapy, administration or supervision of the self-administration of medications, nursing care or medical treatment, unless it has been licensed as an assisted living services agency. It may contract with one or more assisted living services agencies, home health care agencies, or other appropriately licensed health care providers to make available health services for tenants provided by such licensed persons or entities.

(7) Managed residential communities may not require tenants to share units. Sharing of a unit shall be permitted solely upon the request and mutual consent of tenants.

(8) The owner or operating entity shall notify the department and any assisted living services agency that provides services to tenants of the managed residential community, in writing, of any proposed change of ownership or operating entity or elimination of core services at least thirty (30) days prior to the effective date of such proposed change.

(9) The owner or operating entity shall immediately notify any assisted living services agencies servicing the community of any change in the service coordinator.

(10) The managed residential community shall provide the department with unrestricted access to the community, tenants and tenant related documents.

(11) The managed residential community shall notify, in writing, each tenant concerned, the next of kin or legal representative, any third party payers concerned and any assisted living services agency servicing the community at least thirty (30) days prior to the voluntary elimination of its status as a managed residential community and immediately upon the department's order of revocation, refusal to renew or suspension of license of the assisted living services agency. This notice shall include at a minimum:

(A) a statement by the managed residential community identifying which core services and assisted living services shall no longer be provided to tenants and clients; and

(B) information regarding other resources available to tenants and clients to provide health care services.

(d) Governing authority of an assisted living services agency

(1) There shall be a formal governing authority with full legal authority and responsibility for the operation of the agency, which shall be the officers and directors of the corporation, and which shall adopt bylaws or rules that are reviewed in accordance with a schedule established by the governing authority and so dated. Such bylaws or rules shall include, but not necessarily be limited to:

(A) the purpose of the agency;

(B) a delineation of the powers, duties and voting procedures of the governing authority, its officers and committees;

(C) the qualifications for membership, method of selection and terms of office of members and chairpersons of committees;

(D) a description of the authority delegated to the supervisor of the assisted living services agency;

(E) the agency's conflict of interest policy and procedures;

(F) assurances that a written contract shall be maintained with one or more licensed home health care agencies if the licensed home health care agencies are not owned and operated by the managed residential community; and

(G) assurances that a written contract shall be maintained with one or more licensed assisted living services agencies if the agencies are not owned and operated by the managed residential community.

(2) The bylaws or rules shall be available to all members of the governing authority and all individuals to whom authority is delegated.

(3) The governing authority shall:

(A) meet as frequently as necessary to fulfill its responsibilities as stated in subdivision (4) of this subsection, but not less than two (2) times per year;

(B) maintain minutes for each meeting;

(C) ensure that minutes reflect the identity of those members in attendance and that, following approval, such minutes are dated and signed by the secretary; and

(D) ensure that the minutes of any of its meetings or any of its committees are available at any time to the commissioner.

(4) Responsibilities of the governing authority shall include, but not necessarily be limited to:

(A) ensuring the quality of services provided by the agency and the quality of care rendered to clients;

(B) establishing a quality assurance program in accordance with subsection (l) of this section;

(C) selecting and appointing a quality assurance committee;

(D) reviewing and accepting all minutes of meetings held by the quality assurance committee and assuring the implementation of corrective actions identified in these minutes;

(E) adopting and documenting the annual review of the written agency budget;

(F) developing policies and programs and delegating the authority to implement policies and programs;

(G) managing the fiscal affairs of the agency;

(H) establishing a schedule for the review of its bylaws or rules;

(I) establishing a schedule for the submission of the reports described in subsection (g) (2) (G) and (H) of this section to the governing authority;

(J) ensuring that a written contract is maintained between the assisted living services agency and one or more licensed home health care agencies or the managed residential community and one or more licensed home health care agencies unless the assisted living services agency operates under common ownership with the licensed home health care agencies that serve the same managed residential community; and

(K) ensuring that a written contract to include provisions that the assisted living services agency shall monitor the provision of core services to determine if the services are being provided on a regular and continual basis, is maintained between the assisted living services agency and the managed residential community unless the licensed assisted living services agency is under common ownership with the managed residential community.

(5) If an assisted living services agency is owned by or is under common or related ownership with the managed residential communities it serves or a licensed home care agency serving such communities, the governing authority of the related managed residential community or licensed home health care agency may serve as the governing authority of the assisted living services agency provided that the requirements of this subsection are met and minutes of meetings clearly identify discussions related to the assisted living services agency.

(e) General requirements for an assisted living services agency

(1) An agency shall be in compliance with all applicable federal, state and local laws and regulations.

(2) An assisted living services agency, as defined in this section, shall only provide services to individuals residing in a managed residential community.

(3) Any assisted living services agency which contracts individually with a tenant of a managed residential community and is not under contract with the community shall comply with this section.

(4) Each agency shall have a designated office on the site of the managed residential community. This office shall provide adequate and safe space for:

- (A) conferences with clients and their families;
- (B) staff to carry out pre and post client visit activities;
- (C) supervisory conferences with staff;

(D) storage and maintenance of equipment and supplies necessary to provide client services in an area, that may be separate from the business office; and

(E) maintenance of administrative records and files, financial records and client service records in locked file cabinets or an area that can be locked.

(5) Contracted services. Assisted living services agencies may contract with other organizations, agencies or individuals to provide the services defined in subsections (h) and (i) of this section to their clients. Services provided by the primary agency through arrangements with a contracted agency or individuals(s) shall be set forth in either a written contract or a written memorandum of understanding between participating agencies. The provisions set forth in this subdivision shall also apply when services are being provided at the same time to the same client by more than one (1) agency licensed to provide such services. The contract or written memorandum of understanding shall include, but not necessarily be limited to:

(A) a statement that clearly defines the assignment of primary responsibility for the client's care;

(B) the methods of communication and coordination between agencies to ensure that all information necessary for safe, coordinated care to clients is accessible and available to all participating agencies;

(C) the necessity to conform with all applicable primary agency policies, including personnel qualifications and staffing patterns; and

(D) the responsibility of participating agencies in developing and implementing the client service program.

(6) Each assisted living services agency shall have a communication system adequate to receive requests and referrals for service, maintain verbal contact with health service personnel at all times when they are providing services to clients, receive calls from clients under the care of the agency and tenants residing in the community and maintain contact as needed with the client's source of medical care and other providers of care, if applicable.

(7) Assisted living services, including nursing services and assistance with activities of daily living, may be provided to clients with chronic and stable conditions as determined by a physician or health care practitioner with applicable statutory authority at least on an annual basis and as needed. Chronic and stable conditions are not limited to medical or physical conditions, but also include chronic and stable mental health and cognitive conditions. The determination shall be made in writing and maintained in the client's service record.

(8) Each agency shall establish written criteria for admission to assisted living services. The criteria shall not impose unreasonable restrictions which screen out a client whose needs may be met by the agency.

(9) Each agency shall develop written policies for the discharge of clients from the agency. Agency discharge policies shall define categories for the discharge of clients and shall include but not necessarily be limited to:

(A) Change in client's condition. Termination of services when the client's condition is no longer chronic and stable;

(B) Routine discharge. Termination of services when goals of care have been met and the client no longer requires assisted living services;

(C) Emergency discharge. Termination of services due to the presence of safety issues which place the client or agency staff in immediate jeopardy and prevent the agency from delivering assisted living services;

(D) Financial discharge. Termination of services when the client's insurance benefits or financial resources have been exhausted; and

(E) Premature discharge. Termination of services when goals of care have not been met and the client continues to require assisted living services.

(10) Clients and other responsible parties shall be informed when their individual care and service needs may qualify for reimbursement by a third party payor. A summary of the information provided to the client shall be documented in the client service record and shall be signed and dated by the supervisor of assisted living services or his or her designee as well as by the client or the client's representative.

(11) Each agency shall develop and have readily available a policy and procedure to address the appropriate steps to follow in the event of a medical emergency. A review of the policy and procedure shall be included in the employee orientation program.

(12) Each agency shall establish a written complaint procedure regarding the provision of care and services, any allegations of physical or mental abuse or exploitation or the lack of respect for a client's property by anyone providing agency services including, but not necessarily limited to:

(A) a statement that a client or his or her family has the right to file a complaint without discrimination or reprisal from the agency;

(B) the manner in which the agency shall address the complaint with the client or his or her family including a full investigation into the complaint; and

(C) provisions to ensure that the agency shall promptly attempt to resolve complaints.

(13) The agency shall maintain a complaint log which shall include, but not necessarily be limited to the name of the client and the date, nature and resolution of the complaint. The log shall be available to the department upon its request.

(14) The agency shall apprise the client of his or her right to access the appropriate state agency should the complaint not be resolved to the client's satisfaction.

(f) Personnel policies for an assisted living services agency

(1) An agency shall have written personnel policies which shall include but not necessarily be limited to the following:

(A) Each agency shall have an orientation policy and procedure for all employees which shall include but not necessarily be limited to the following:

- (i) organizational structure of the agency and philosophy of assisted living services;
- (ii) agency client services policies and procedures;
- (iii) agency personnel policies;
- (iv) applicable regulations governing the delivery of assisted living services; and
- (v) orientation dates, content, and name and title of the person providing the orientation as documented in the employee's personnel folder.

(B) Each agency shall have an in-service education policy that provides an annual average of at least one (1) hour bimonthly for each assisted living aide.

(i) The in-service education shall include, but not necessarily be limited to current information regarding specific service procedures and techniques and information related to the population being served.

(ii) The in-service education program shall be provided by or under the supervision of the supervisor of assisted living services or a designated licensed nurse who possesses a minimum of two (2) years of full time or full time equivalent experience in nursing, at least one (1) year of which shall be in a home health care agency or community health program that included care of the sick at home.

(iii) An assisted living services agency that utilizes an aide from a placement agency or nursing pool shall maintain sufficient documentation to demonstrate that in-service education requirements are met.

(iv) A nursing home or home health care agency having the same ownership as, or under common or related ownership with, as assisted living services agency may provide joint in-service education programs for all aides, provided that records of such in-services clearly reflect content, attendance and work location.

(v) An assisted living services agency may contract with a home health care agency or nursing home to provide in-service education to its assisted living aides in accordance with this section.

(C) Each agency shall have a policy and procedure for the annual performance evaluation of employees which includes a process for corrective action when an employee receives an unsatisfactory performance evaluation.

(D) Agency personnel policies and procedures shall include written job descriptions that specify the duties and qualifications of each job.

(E) Agency policies and procedures shall address documentation by a physician or health care practitioner with applicable statutory authority of annual physical examinations, including tuberculin testing, that are performed for the purpose of preventing infection or contagion from communicable disease. A statement that the

employee is free from communicable disease, including results of the tuberculin testing, shall be obtained prior to assignment to client care activities.

(2) For all employees of the agency employed directly or via individual or agency contracts, the agency shall maintain individual personnel records containing at least the following:

(A) educational preparation and work experience;

(B) written verification of successful completion of a home health aide training and competency evaluation program or a competency evaluation program approved by the commissioner in accordance with Section 19-13-D8t (l), Section 19-13-D69 (d) (2) or Section 19-13-D83 (b) of the regulations of Connecticut State Agencies, if applicable;

(C) current licensure, if applicable;

(D) written annual performance evaluations;

(E) record of health examinations; and

(F) documentation of orientation.

(3) For persons utilized via contract with another assisted living services agency, a home health care agency, homemaker-home health aide agency or nursing pool, the assisted living services agency shall ensure it has access to the personnel records required in subdivision (2) of this subsection and shall make the documents available to the department upon its request.

(4) An assisted living services agency owned by, or under common or related ownership with, a nursing home or home health care agency, may maintain one (1) personnel file for each employee or independent contractor utilized by the nursing home or home health care agency and the assisted living services agency.

(g) **Supervisor of assisted living services**

(1) The supervisor of assisted living services shall be a registered nurse licensed to practice in this state who has one of the following:

(A) a baccalaureate degree in nursing and a minimum of two (2) years full time or full time equivalent clinical experience in nursing, at least one (1) of which shall be in a home health care agency or community health program that included care of the sick at home; or

(B) a diploma or associate's degree in nursing and at least four (4) years full time or full time equivalent clinical experience in nursing within the past ten (10) years, at least one (1) year of which shall be in a home health care agency or community health program that included care of the sick at home.

(2) The supervisor's responsibilities include, but are not necessarily limited to:

(A) coordinating and managing all nursing and assisted living aide services rendered to clients by direct service staff under his or her supervision;

(B) supervising assigned nursing personnel and assisted living aides in the delivery of nursing services and assistance with the provision of activities of daily living;

(C) ensuring the evaluation of the clinical competence of assigned nursing personnel and assisted living aides;

(D) participating in or developing all agency objectives, standards of care, policies and procedures concerning nursing services and the provision of assistance with activities of daily living;

(E) participating in direct service staff recruitment, selection, orientation and in-service education;

(F) participating in program planning, budgeting and evaluating activities related to the clinical services provided by the agency;

(G) providing weekly reports to the service coordinator regarding any problems associated with the provision of the core services, or any problems or concerns associated with the managed residential community or the assisted living services agency, summaries of which shall be provided to the governing authority in accordance with the schedule established by the governing authority; and

(H) providing monthly reports to the service coordinator regarding statistical data including the number of clients served and services provided, summaries of which shall be provided to the governing authority in accordance with the schedule established by the governing authority.

(3) The supervisor of assisted living services may provide direct nursing services to clients in accordance with subsection (h) of this section.

(4) Any absence of the supervisor of assisted living services longer than one (1) month shall be reported to the commissioner. A registered nurse with a minimum of two (2) years full time or full time equivalent clinical experience in nursing, at least one (1) year of which shall be in a home health care agency or community health program that included care of the sick at home, shall be designated, in writing, to act during any absence of the supervisor of assisted living services.

(h) Nursing Services provided by an assisted living services agency

(1) An assisted living services agency shall have written policies governing the delivery of nursing services.

(2) Nursing services shall be provided by licensed nurses in accordance with subparagraph (J) of subdivision (3) of this subsection.

(3) A registered nurse shall be responsible for the following which shall be documented in the client's service record:

(A) admission of clients for service;

(B) development of the client service program and instructions for assisted living aide services;

(C) assessments, completed as often as necessary based on the client's condition but not less frequently than every one hundred and twenty (120) days, and prompt action when a change in the client's condition would require a change in the client's service program;

(D) coordination of services with the client, family, and other appropriate individuals involved in the client service program;

(E) participation in orientation, teaching, and supervision of assisted living aides;

(F) arrangements for training or supervision of the assisted living aide by other professionals, when appropriate;

(G) referral to appropriate professionals or agencies, whenever the client's condition necessitates, including the provision of current clinical information ensuring that if the client's condition is no longer chronic and stable, services of a licensed home health care agency are engaged or other appropriate arrangements are made;

(H) planning for clients who shall no longer receive or require the services of the assisted living services agency;

(I) implementation or delegation of responsibility for the availability of nursing services on a twenty-four (24) hour basis;

(J) nursing services which shall include, but not necessarily be limited to:

(i) client teaching;

(ii) wellness counselling;

(iii) health promotion;

(iv) disease prevention;

(v) medication administration and delegation of supervision of self-administered medications as specified in subdivision (4) of this subsection; and

(vi) provision of care and services to clients whose conditions are chronic and stable as defined in subdivision (7) of subsection (e).

(4) Supervision of medication administration by an assisted living service agency shall be provided in accordance with the following:

(A) A licensed nurse may administer medications to clients under the written order of a physician or health care practitioner with applicable statutory authority.

(B) A licensed nurse may pre-pour medications for clients who are able to self-administer medications, under the written order of a physician or health care practitioner with applicable statutory authority.

(C) With the approval of the client or his or her representative an assisted living aide may supervise a client's self-administration of medications. The aide shall only:

(i) remind a client to self administer the medications;

(ii) verify that a client has self administered their medications; or

(iii) assist the client with the self administration in the form of opening bottles, bubble packs or other forms of packaging if the client is not capable of performing this function.

(D) For clients who require only supervision of self-administration, a registered nurse may verbally verify the client's medication regimen with the client's physician or health care practitioner with applicable statutory authority and document the medication regime in the client's service record.

(E) The registered nurse shall verify written or verbal orders from the physician or health care practitioner with applicable statutory authority as needed, but at least once every one hundred and twenty (120) days.

(F) All medications shall be stored within a client's private residential unit.

(G) A licensed nurse shall ensure that the client or his or her representative is aware of the client's medication regime and able to make decisions regarding medication administration.

(i) Assisted living aide services provided by an assisted living services agency

(1) An assisted living services agency shall have written policies governing the delivery of services by an assisted living aide.

(2) Any person who furnishes assisted living services on behalf of an assisted living services agency shall have successfully completed a training and competency evaluation program in accordance with Section 19-13-D8t (j), Section 19-13-D69 (d) (2) or Section 19-13-D83 (b) of the regulations of Connecticut State Agencies, and shall have completed ten (10) hours of orientation prior to providing any direct client care service. This orientation shall be provided by the supervisor of assisted living services or a licensed nurse designated by the supervisor.

(3) When designated by the licensed nurse responsible for a client's care and services, the duties of the assisted living aide may include:

(A) assisting the client with personal care activities including bathing, oral hygiene, feeding, dressing, toileting and grooming;

(B) assisting the client with exercises, ambulation, transfer activities and supervision of self-administered medication; and

(C) performing routine household services essential to client care at home, including shopping, meal preparation, laundry and housecleaning.

(4) An assisted living services agency is not required to provide the services described in subparagraph (C) of subdivision (3) of this subsection. These services may be provided by an assisted living aide or any other person.

(5) Supervision of assisted living aides

(A) A registered nurse shall be accessible by telephone and available to make a home visit at all times, including nights, weekends and holidays, when assisted living aides are on assignment in a client's home.

(B) The licensed nurse assigned to the client is responsible for supervision of the services rendered by the assisted living aide.

(j) Assisted living services agency staffing requirements

(1) An assisted living services agency shall appoint, with the written approval of the governing authority, a supervisor of assisted living services and a designee, as described in subsection (g) of this section.

(2) An assisted living services agency shall employ or contract with at least one (1) registered nurse in addition to the supervisor of assisted living services. This registered nurse may serve as the designee in the absence of the supervisor and shall be available to provide relief for the supervisor as needed.

(3) The agency shall employ a supervisor of assisted living services to be on site as follows:

(A) at least twenty (20) hours per week for each ten (10) or less full time or full time equivalent licensed nurses or assisted living aides; or

(B) at least forty (40) hours per week for each twenty (20) or less full time or full time equivalent licensed nurses or assisted living aides.

(4) In addition to the supervisor of assisted living services, the agency shall be staffed with licensed nurses at least ten (10) hours per week for each additional ten (10) or less full time or full time equivalent assisted living aides.

(5) The supervisor of assisted living services shall be responsible for ensuring that licensed nurse staffing is adequate at all times to meet client needs.

(6) All registered nurses shall be supervised directly by the supervisor of assisted living services.

(7) All licensed practical nurses shall be supervised by the supervisor of assisted living services or a registered nurse designated by said supervisor.

(8) An assisted living services agency shall designate a registered nurse to be on call twenty-four (24) hours a day. The on-call registered nurse shall have two (2) years of full time or full time equivalent clinical experience in nursing, at least one (1) year of which shall be in a home health care agency or community health program that included care of the sick at home. The on-call registered nurse may be the supervisor of assisted living services or another registered nurse as specified in this section. An assisted living services agency may contract for on-call registered nurse services with a licensed home health care agency. The on-call nurse shall be reachable by telephone and shall be available to make an on-site visit, if necessary in order to:

(A) respond to the assisted living aides during the provision of care to clients; and

(B) respond to client emergencies.

(9) In an assisted living services agency that serves no more than thirty (30) clients on a daily basis, one (1) individual may serve as both the supervisor of assisted living services and the service coordinator, as described in subdivision (5) of subsection (C) of this section, provided that the assisted living services agency is owned by, or under common or related ownership with the management of the managed residential community. The minimum qualifications required for the supervisor of assisted living services shall be sufficient to meet the minimum qualifications required for these shared positions. In the event that the monthly

average of clients served per day exceeds thirty (30) for two (2) consecutive months, the agency shall not qualify for the sharing of the positions.

(10) The supervisor of assisted living services shall be responsible for ensuring that sufficient numbers of assisted living aides are available to meet the needs of clients at all times based on the clients' service programs.

(k) Client service record

(1) Each assisted living services agency shall maintain a complete service record for each client. All parts of the record pertinent to the daily care and treatment of the client shall be located in an accessible area on the campus of the managed residential community. The agency shall use a format that shall be provided by the department.

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

(A) client identifying data including name, date of birth, sex, date of admission or readmission, marital status, and religion;

(B) name of family member or significant other, including address and telephone number;

(C) name, location and phone number of client's personal physician or source of medical care;

(D) complete medical diagnoses;

(E) all initial and subsequent orders by the physician or health care practitioner with applicable statutory authority, if applicable;

(F) assessment of the client including pertinent past and current health history, physical, mental and social status, and evaluation of client's needs;

(G) annual and other certifications by a physician or health care practitioner with applicable statutory authority of the client's chronic and stable condition;

(H) a client service program, completed by a registered nurse in consultation with the client, family and others involved in the care of the client, within seven (7) days of the client's admission to the agency, which shall be reviewed as often as the client's condition requires but not less than once every one hundred and twenty (120) days, shall be explained to, reviewed with and agreed to by the client or his or her representative, shall reflect the client's or his or her representative's or family's preferences and choices regarding client services, and shall include but not necessarily be limited to:

(i) identification of client's problems and needs;

(ii) goals of management, plans for intervention and implementation;

(iii) types and frequency of services and equipment required;

(iv) types and frequency of services to be provided by the client's family or informal support system;

(v) medications to be self-administered with supervision or administered by a licensed nurse, treatments and other required nursing services;

(vi) written instructions for the assisted living aide which shall be completed before the assisted living aide provides care and services to include the scope and limitations of the assisted living aide's activities and pertinent aspects of the client's condition to be observed and reported to the registered nurse; and

(vii) frequency and plan for registered nurse supervision of the assisted living aides, including methods of ensuring ongoing competence of the assisted living aide;

(I) nurses notes including changes in client conditions and notification of appropriate source of medical care, family member or significant other, treatments, and responses to such treatments;

(J) a record of medications administered, including medications pre-poured for the client or medications refused by the client;

(K) documentation of coordination of services with the client, family, and others involved in the client service program;

(L) documentation of all care and services rendered, including assisted living aide notes which have been reviewed by the registered nurse; and

(M) referrals and discharge summary, if applicable.

(3) Upon a client's referral to a home health care agency, the name of the agency to which the client was referred and a summary of the reason(s) for the referral shall be documented in the client record including the staff person contacted and the date of contact with the agency.

(4) Upon a client's resumption of services by an assisted living services agency, a summary of the care and services provided to the client by the home health care agency shall be documented in the client record.

(5) All entries in the client service record shall be typewritten or written in ink and legible. All entries shall be verified according to accepted professional standards.

(6) Client service records shall be safeguarded against loss, destruction or unauthorized use.

(7) All client service records, originals or copies, shall be preserved for at least seven (7) years following death or discharge of the client from the assisted living services agency.

(8) Client records shall be confidential. Written consent shall be obtained from the client prior to the release of information to persons not otherwise authorized under law to receive said information.

(I) Quality assurance program for an assisted living service agency

(1) There shall be a quality assurance committee, appointed by the governing authority, consisting of at least one (1) physician, one (1) registered nurse with a minimum of two (2) years of clinical experience in home health care or one (1) nurse with a bachelor's degree in nursing and one (1) social worker with a bachelor's degree in social work or in a related human service field. Representatives appointed to the committee shall be in active practice in their profession or shall have been in active practice within the last five (5) years. No member of the quality assurance committee shall be an owner, stockholder, employee of the agency or related by blood or marriage to an owner, stockholder or employee of the agency. However, provision may be made for employees to serve on the committee as ex officio members only, without voting powers. The service coordinator of a managed residential community may be appointed to serve as the social worker for the assisted living services agency's quality assurance committee provided that the agency is not owned by, or under common or related ownership with the managed residential community.

(2) The quality assurance committee shall meet at least once every one hundred and twenty (120) days.

(3) Written minutes shall document dates of meetings, attendance, and recommendations. The minutes shall be presented and acted on at the next regular meeting of the governing authority of the agency following the quality assurance committee meeting. These minutes shall be available to the department upon its request.

(4) The professional advisory committee of a home health care agency that owns, or is under common or related ownership with, an assisted living services agency may also serve as the quality assurance committee for the assisted living services

agency, provided that minutes and other records clearly distinguish committee activities.

(5) The functions of the quality assurance committee shall be to participate in the agency's quality assurance program to the extent defined in the quality assurance program policies and to, at least annually, review and revise, if necessary, the agency's policies on:

- (A) program evaluation;
- (B) assessment and referral criteria;
- (C) service records;
- (D) evaluation of client satisfaction;
- (E) personnel qualifications;
- (F) standards of care; and

(G) professional issues, especially as they relate to the delivery of services and findings of the quality assurance program.

(6) Each agency shall have a written quality assurance program which shall include, but not necessarily be limited to:

- (A) program evaluation; and
- (B) client record review.

(7) The quality assurance committee shall conduct the program evaluation, which shall include, but not necessarily be limited to:

(A) the extent to which the managed residential community's policies and resources are adequate to maintain core services on a regular and continual basis and are appropriate to the community tenants and family needs; and

(B) the extent to which the agency's objectives, policies and resources, are adequate to meet health and personal care needs of the managed residential community tenants, including referral to other health care services agencies or professionals, as appropriate.

(8) At least every one hundred and twenty (120) days, the quality assurance committee shall review a random sample of active and closed client records. Each record review shall be documented on a record review form and shall include, but not necessarily be limited to verification that:

- (A) agency policies are followed in the provision of services to clients;
- (B) services are provided only to clients whose level of care needs can be met by an assisted living services agency;
- (C) provision of care is coordinated within the agency involved in the care of the client; and

(D) referral of the client is made to a home health care agency or other services of care or health care professionals when the client's status and care needs are no longer limited to the services provided by an assisted living services agency.

(9) The agency's sampling methodology for reviewing client records shall be defined in its quality assurance program policies and procedures.

(10) An annual written report of the agency's quality assurance program shall summarize all findings and recommendations resulting from the quality assurance activities. This report and documentation of all actions taken as a result of the findings or recommendations included in the report shall be available to the department.

(m) **Client's bill of rights and responsibilities.** An assisted living services agency shall have a written bill of rights and responsibilities governing agency services which shall be provided and explained to each client at the time of admission to the agency. Such explanation shall be documented in the client's service record.

All clients shall receive a written copy of any changes made to the bill of rights. The bill of rights shall include but not necessarily be limited to:

(1) description of available services, charges and billing mechanisms with the assurance that any changes shall be given to the client orally and in writing as soon as possible but no less than fifteen (15) working days prior to the date such changes become effective;

(2) criteria for admission to service;

(3) information regarding the right to participate in the planning of (or any changes in) the care to be furnished, the frequency of visits proposed, the nurse supervising care and the manner in which the nurse may be contacted;

(4) client responsibility for participation in the development and implementation of the client service program and the client's right to refuse recommended services;

(5) right of the client to be free from physical and mental abuse and exploitation and to have personal property treated with respect;

(6) explanation of confidential treatment of all client information retained in the agency and the requirement for written consent for release of information to persons not otherwise authorized under law to receive it;

(7) policy regarding client access to his or her service record;

(8) explanation of the complaint procedure and right to file a complaint without discrimination or reprisal from the agency regarding the provision of care and services, any allegations of physical or mental abuse or exploitation or the lack of respect for property by anyone providing agency services;

(9) agency's responsibility to promptly investigate the complaints made by a client or his or her family regarding the provision of care and services, any allegations of physical or mental abuse or exploitation or lack of respect for the client's property by anyone providing agency services;

(10) procedure for registering complaints with the commissioner including the address and phone number of the department;

(11) the client's right to have services provided by an individual or entity other than via an assisted living services agency;

(12) the circumstances under which the client may be discharged from the agency or may not be permitted to receive services from the assisted living services agency;

(13) a description of Medicare-covered services and billing and payment requirements for such services;

(14) information advising the client of his or her rights under state law to make decisions about medical care, including the right to formulate advance directives such as living wills and durable power of attorney for health care decisions;

(15) the client's right to make individual arrangements with an assisted living services agency which does not have a formal contract with the managed residential community in which he or she resides; and

(16) the client's right to terminate or reduce services provided by an assisted living services agency at any time.

(Effective November 29, 1994; amended June 29, 2001)