44:04:01:02. Licensure of facilities by classification.
... The most current license issued by the department must be posted on the premises of the facility in a place conspicuous to the public. Each facility address shall show a current license.

44:04:01:03. Name of facility. Each facility must be designated by a pertinent and distinctive name that must be used in applying for a license. The name may not be changed without first notifying the department in writing. No facility may be given a name or advertise in a way that implies services rendered are in excess of the classification for which it is licensed or which would indicate an ownership other than actual.

44:04:01:06. Joint occupancy. The use of a portion of a building for purposes other than that covered by the license may be approved by the department only if it can be shown that joint occupancy is not detrimental to the welfare of the patients or residents. The area must be open to inspection by the department.

44:04:01:07. Reports. Each licensed facility, when requested by the department, shall submit to the department the pertinent data necessary to comply with the requirements of SDCL chapter 34-12 and this article. Each facility shall report to the department within 48 hours of the event any death resulting from other than natural causes originating on facility property such as accidents, abuse, negligence, or suicide; any missing patient or resident; and any allegation of abuse or neglect of any patient or resident by any person. Each facility shall report the results of the investigation within five working days after the event. Each facility shall also report to the department as soon as possible any fire with structural damage or where injury or death occurs; any partial or complete evacuation of the facility resulting from natural disaster; or any loss of utilities, such as electricity, natural gas, telephone, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for operation of the facility for more than 24 hours. Each facility shall notify the department of any anticipated closure or discontinuation of service at least 30 days in advance of the effective date.

44:04:02:09. Infection control... The facility must provide orientation and continuing education to all personnel on the facility's staff on the cause, effect, transmission, prevention, and elimination of infections.

44:04:03:02. General fire safety. Each licensed health care facility covered under this article must be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of its occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The fire alarm system must be sounded each month. A minimum of two staff members must be on duty at all times. In multilevel facilities, at least one staff member must be on duty on each floor containing occupied beds. Compliance with this section does
not eliminate or reduce the necessity for other provisions for safety of persons using the structure under normal occupancy conditions.

44:04:04:02. Governing body. Each facility operated by limited liability partnership, a corporation, or political subdivision must have an organized governing body legally responsible for the overall conduct of the facility. If the facility is operated by an individual or partnership, the individual or partnership shall carry out the functions in this chapter pertaining to the governing body. The governing body shall establish and maintain administration policies, procedures, or bylaws governing the operation of the facility. The governing body of a hospital shall determine which categories of practitioners are eligible candidates for appointment to the medical staff and shall credential and grant admitting or patient care privileges to appointees to the medical staff. The governing body may appoint members to the medical staff only after considering the recommendations of the existing members of the medical staff.

44:04:04:03. Administrator. The governing body must designate a qualified administrator to represent the owner or governing body and to be responsible for the daily overall management of the facility. The administrator must designate a qualified person to represent the administrator during the administrator's absence. The governing body shall notify the department in writing of any change of administrator. The administrator of a nursing facility must be licensed pursuant to article 20:49.

44:04:04:04. Personnel. The facility must have a sufficient number of qualified personnel to provide effective and safe care. Staff members on duty must be awake at all times. Supervisors must be 18 years of age or older. Written job descriptions and personnel policies and procedures must be made available to personnel of all departments and services. The facility may not knowingly employ any person with a conviction for abusing another person. The facility must establish and follow policies regarding special duty or staff members on contract.

44:04:04:05. Personnel training. The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects:
(1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff;
(2) Emergency procedures and preparedness;
(3) Infection control and prevention;
(4) Accident prevention and safety procedures;
(5) Proper use of restraints;
(6) Patient and resident rights;
(7) Confidentiality of patient or resident information;
(8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms;
(9) Care of patients or residents with unique needs; and
(10) Dining assistance, nutritional risks, and hydration needs of residents. Personnel whom the facility determines will have no contact with patients or residents are exempt from
training required by subdivisions (5), (9), and (10) of this section. Current professional and technical reference books and periodicals must be made available for personnel.

44:04:04:11. Care policies. Each facility must establish and maintain policies, procedures, and practices to govern care, and related medical or other services necessary to meet the patients’ or residents’ needs. Policies and procedures for the management of adult day care clients and respite care patients or residents in the facilities offering those services shall be established and maintained.

44:04:04:15. Transfer agreements. Each nursing facility must have in effect a transfer agreement with one or more hospitals sufficiently close to provide prompt inpatient hospital care to the facility’s residents when needed. The agreement must provide for an interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the facilities. Each specialized hospital and critical access hospital must have in effect a transfer agreement with one or more hospitals to provide services not available on site. The agreement must provide for an interchange of medical and other necessary information; and Each ambulatory surgery center must have in effect a transfer agreement with a hospital sufficiently close to accept emergency transfer of patients.

44:04:04:16. Quality assessment. Each licensed facility shall provide for on-going evaluation of the quality of services provided to patients or residents. Components of the quality assessment evaluation must include establishment of facility standards; interdisciplinary review of patient or resident services to identify deviations from the standards and actions taken to correct deviations; patient or resident satisfaction surveys; utilization of services provided; and documentation of the evaluation and report to the governing body.

44:04:05:07. Medical director required. A critical access hospital and a nursing facility must appoint a physician licensed in South Dakota to serve as a medical director. The medical director shall assure physician services are provided only by qualified caregivers.

44:04:06:03. Director of nursing service. There must be a full-time registered nurse designated as the director of nursing service who is responsible for the organization of the total nursing service and who serves during the day shift. The director may not serve in a dual role as the administrator of the facility and the director of nursing.

44:04:07:16. Required dietary inservice training. The dietary manager or the dietitian in hospitals and nursing facilities, and the person-in-charge of dietary services or the dietitian in assisted living centers shall provide ongoing inservice training for all dietary and food-handling employees. The person-in-charge of any hospital without an in-house dietary department that uses a contracted dietary service shall provide ongoing inservice training for all dietary and food handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.
44:04:09:01. Record services for hospitals and nursing facilities. All hospitals and nursing facilities must comply with §§ 44:04:09:02 to 44:04:09:05, inclusive.

44:04:09:02. Medical record department. There must be an organized medical record system. A medical record must be maintained for each level of care for each patient or resident admitted to the facility.

44:04:09:03. Medical record department staff. The medical record functions must be performed by persons trained and equipped to facilitate the accurate processing, checking, indexing, filing, and retrieval of all medical records. The individual responsible for the medical records service must have knowledge and training in the field of medical records.

44:04:09:04. Written policies and confidentiality of records. There must be written policies and procedures to govern the administration and activities of the medical record service. They must include policies and procedures pertaining to the confidentiality and safeguarding of medical records, the record content, continuity of a patient's or resident's medical records during subsequent admissions, requirements for completion of the record, and the entries to be made by various authorized personnel.

44:04:09:05. Record content. Each medical record must show the condition of the patient or resident from the time of admission until discharge and must include the following:
(1) Identification data;
(2) Consent forms, except when unobtainable;
(3) History of the patient or resident;
(4) A current overall plan of care;
(5) Report of the initial and periodic physical examinations, evaluations, and all plans of care with subsequent changes;
(6) Diagnostic and therapeutic orders;
(7) Progress notes from all disciplines, including practitioners, physical therapy, occupational therapy, and speech pathology;
(8) Laboratory and radiology reports;
(9) Description of treatments, diet, and services provided and medications administered;
(10) All indications of an illness or an injury, including the date, the time, and the action taken regarding each;
(11) A final diagnosis; and
(12) A discharge summary, including all discharge instructions for home care.

44:04:09:07. Authentication. A health care facility must ensure entries to the medical or care record are signed or electronically authenticated. If the facility permits any portion of the medical or care record to be generated by electronic or optical means, policies and procedures must exist to prohibit the use of authentication by unauthorized users.

44:04:09:08. Retention of medical or care records. A health care facility must retain medical or care records for a minimum of ten years from the actual visit date of service or resident care. The retention of the record for ten years is not affected by additional and future visit dates. Records of minors must be retained until the minor reaches the age of majority plus an additional two years, but no less than ten years from the actual visit date.
of service or resident care. Initial, annual, and significant-change resident assessment records, as required in §§ 44:04:06:15 and 44:04:06:16, must be retained for ten years from the actual visit date of resident care. The retention of the record for ten years is not affected by additional and future visit dates.

44:04:09:09. Storage of medical or care records. A health care facility must provide for filing, safe storage, and easy accessibility of medical or care records. The medical or care records must be preserved as original records or in other readily retrievable and reproducible form. Medical or care records must be protected against access by unauthorized individuals. All medical or care records must be retained by the health care facility upon change of ownership.

44:04:09:10. Destruction of medical or care records. After the minimum retention period of ten years from the actual visit date of care outlined in § 44:04:09:08, the medical or care record may be destroyed at the discretion of the health care facility. Before the destruction of the medical or care record, the health care facility must prepare and retain a patient or resident index or abstract. The patient or resident index or abstract must include:
   (1) Name;
   (2) Medical record number;
   (3) Date of birth;
   (4) Summary of visit dates;
   (5) Attending or admitting physician; and
   (6) Diagnosis or diagnosis code. The health care facility must destroy the medical or care record in a way that maintains confidentiality.

44:04:09:11. Disposition of medical or care records on closure of facility or transfer of ownership. If a health care facility ceases operation, the facility must provide for safe storage and prompt retrieval of medical or care records and the patient or resident indexes specified in § 44:04:09:10. The health care facility may arrange storage of medical or care records with another health care facility of the same licensure classification, transfer medical or care records to another health care provider at the request of the patient or resident, relinquish medical records to the patient or resident or the patient’s or resident’s parent or legal guardian, or arrange storage of remaining medical records with a third party vendor who undertakes such a storage activity. At least 30 days before closure, the health care facility must notify the department in writing indicating the provisions for the safe preservation of medical or care records and their location and publish in a local newspaper the location and disposition arrangements of the medical or care records. If ownership of the health care facility is transferred, the new owner shall maintain the medical or care records as if there was not a change in ownership.

44:04:18:02. Employment of qualified nurse aides required. Nurse aides employed by a nursing facility must meet the following minimum qualifications of training, competency evaluation, registry status, and performance:
   (1) Successful completion of a training program and a competency evaluation program approved by the department pursuant to §§ 44:04:18:07 and 44:04:18:17;
(2) Verification from the department of current registry status or eligibility for inclusion on
the registry;
(3) Acceptable employment performance as a nurse aide as documented by the aide’s
supervisor; and
(4) Annual attendance at a minimum of 12 hours of in-service education related to results
of performance review and of special resident needs.

44:04:18:03. Exception for employment of unqualified nurse aides. A nursing facility may
employ for a maximum of four months an individual to provide nurse aide duties who has
not met the qualifications of § 44:04:18:02 if the individual is enrolled in a training and
competency evaluation program approved by the department pursuant to §§ 44:04:18:07
and
44:04:18:17 or if the individual can prove that approved training and competency
evaluation has been completed and the individual has not yet been included on the registry.
The nursing facility must ensure that such an individual actually obtains registry status
within the four-month period.

44:04:18:04. Multistate registry verification required. A nursing facility must seek
information from every state registry that the facility has reason to believe has information
on the individual before allowing the individual to work as a nurse aide.

44:04:18:05. Nursing facility required to maintain records. A nursing facility must maintain
employment records that verify the qualifications of the nurse aides as outlined in §
44:04:18:02.

44:04:18:06. Nursing facility required to pay costs of training and competency evaluation.
A nursing facility must pay all costs of nurse aide training and competency evaluation or
reimburse the nurse aide for the cost incurred in completing the program if the facility
employs the aide within twelve months following completion of the training program.
Reimbursement may be made during the first twelve months of employment by
installments.

44:04:18:07. Approval and reapproval of nurse aide training programs. The department
must approve nurse aide training programs. To obtain approval, the entity providing the
nurse aide training program must submit to the department an application on a form
provided by the department that contains information demonstrating compliance with
requirements specified in this chapter. The department shall respond within 90 days after
receipt of the application. The department may grant approval for a maximum of two years.
At the end of the approval period, the entity must apply for reapproval. As part of the
reapproval process, the department shall conduct an unannounced on-site visit to
determine compliance with the requirements.

44:04:18:08. Notice of change in approved training program. The entity offering an
approved nurse aide training program must submit to the department, within 30 days after
the change, any substantive changes made to the program during the two-year approval
period. The department shall notify the entity of its approval within 90 days after receipt of
the information.
44:04:18:09. Denial or withdrawal of approval of training program. The department may deny or withdraw approval of a nurse aide training program if one of the following conditions applies to the nursing facility within the 24 months preceding the current survey:

1. The facility has been found to be out of compliance with the provision of care requirements in chapter 44:04:04 or the nursing service requirements in chapter 44:04:06;
2. The facility has been issued a probationary license;
3. The facility refuses to permit an unannounced visit by the department;
4. The facility fails to maintain a 75 percent pass rate on the competency evaluation for the two-year approval period;
5. There is evidence that the facility has charged the nurse aide a fee for a portion of the training or competency evaluation. The department shall notify the entity in writing of the reason for withdrawal or denial of approval. Nurse aides currently enrolled in a program whose approval is withdrawn may complete the program with that entity.

44:04:18:10. Qualifications of program coordinator. The program coordinator of a nurse aide training program must be a registered nurse. The program coordinator is responsible for the general supervision of the program. General supervision means providing guidance for the program and maintaining ultimate responsibility for the course. The program coordinator must have a minimum of two years of nursing experience, at least one year of which is in the provision of long-term care services. The director of nursing of a facility may serve simultaneously as the program coordinator but may not perform training while serving as the director of nursing.

44:04:18:11. Qualifications of primary instructor. The primary instructor of a nurse aide training program must be a licensed nurse. The primary instructor is the actual teacher of course material. The primary instructor must have a minimum of two years of nursing experience, at least one year of which is in the provision of long-term care services. The primary instructor must have completed a course of instruction in teaching adults or must have experience in teaching adults within the past five years.

44:04:18:12. Qualifications of supplemental personnel. Supplemental personnel may assist with the instruction of nurse aides. One year of experience in the individual's respective field of practice is required.

44:04:18:13. Supervision of students. Students in a nurse aide training program may not perform any services unless they have been trained and found to be proficient by the instructor. Students in a training program may perform services only under the supervision of a licensed nurse.

44:04:18:14. Physical facilities. Classrooms, conference rooms, laboratories, and equipment must be available in the number and size to accommodate the number of nurse aides enrolled in the training program. Programs must provide temperature control, lighting, and clean, safe conditions for instruction.
Nurse aide curriculum. The curriculum of the nurse aide training program must address the medical, psychosocial, physical, and environmental needs of the patients or residents served by the nursing facility. Each unit of instruction must include behaviorally stated objectives with measurable performance criteria. The nurse aide training program must consist of at least 75 hours of classroom and clinical instruction, including the following:

1. Sixteen hours of training in the following areas before the nurse aide has any direct contact with a patient or resident:
   - Communication and interpersonal skills;
   - Infection control;
   - Safety/emergency procedures, including the Heimlich maneuver;
   - Promoting patients' and residents' independence; and
   - Respecting patients' and residents' rights;

2. Sixteen hours of supervised practical training, with enough instructors to ensure that nursing care is provided with effective assistance and supervision. The ratio may not be less than one instructor for each eight students in the clinical setting;

3. Instruction in each of the following content areas:
   - Basic nursing skills:
     - Taking and recording vital signs;
     - Measuring and recording height and weight;
     - Caring for the patients' or residents' environment;
     - Recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor; and
     - Caring for patients or residents when death is imminent;
   - Personal care skills, including the following:
     - Bathing;
     - Grooming, including mouth care;
     - Dressing;
     - Toileting;
     - Assisting with eating and hydration;
     - Feeding techniques;
     - Skin care; and
     - Transfers, positioning, and turning;
   - Mental health and social services:
     - Modifying aides' behavior in response to patients' or residents' behavior;
     - Awareness of developmental tasks associated with the aging process;
     - How to respond to patients’ or residents’ behavior;
     - Allowing the patient or resident to make personal choices, providing and reinforcing other behavior consistent with the patient’s or resident’s dignity; and
     - Using the patient’s or resident’s family as a source of emotional support;
   - Care of cognitively impaired patients or residents, including the following:
     - Techniques for addressing the unique needs and behaviors of individuals with dementia;
     - Communicating with cognitively impaired patients or residents;
     - Understanding the behavior of cognitively impaired patients or residents;
     - Appropriate responses to the behavior of cognitively impaired patients or residents; and
Methods of reducing the effects of cognitive impairments;

Basic restorative nursing services, including the following:

(i) Training the patient or resident in self-care according to the patient's or resident's abilities;
(ii) Use of assistive devices in transferring, ambulation, eating, and dressing;
(iii) Maintenance of range of motion;
(iv) Proper turning and positioning in bed and chair;
(v) Bowel and bladder control care training; and
(vi) Care and use of prosthetic and orthotic devices;

Residents' rights, including the following:

(i) Providing privacy and maintaining confidentiality;
(ii) Promoting the patients' or residents' right to make personal choices to accommodate their needs;
(iii) Giving assistance in reporting grievances and disputes;
(iv) Providing needed assistance in getting to and participating in resident and family groups and other activities;
(v) Maintaining care and security of patients' or residents' personal possessions;
(vi) Promoting the patient's or resident's right to be free from abuse, mistreatment, and neglect and understanding the need to report any instances of such treatment to appropriate facility staff;
(vii) Avoiding the need for restraints.

Equivalency of education. An individual may meet the 75-hour training requirement by equivalency of education. A nursing facility shall make a request to the department in writing for an equivalency determination, including proof of training with the request.

Nurse aide competency evaluation program standards. A nurse aide competency evaluation program must meet the following standards:

(1) The nurse aide must be informed by the facility that a record of successful completion of the evaluation will be included in the registry;
(2) The evaluation must consist of two elements:
   (a) The competency evaluation component may be offered as either a written or oral examination. This component of the evaluation must:
      (i) Include each curriculum requirement specified in § 44:04:18:15;
      (ii) Be developed from a pool of test questions, with no more than 20 percent of prior questions used on a succeeding examination;
      (iii) Use a system that prevents disclosure of the content of the examination; and
      (iv) If oral, be read from a prepared text in a neutral manner;
   (b) The skills demonstration component must consist of a minimum of five tasks randomly selected from a pool of tasks generally performed by nurse aides. The pool of skills must include all of the personal care skills listed in subdivision 44:04:18:15(3)(b). The skills demonstration tasks must be performed on a live person.

Competency evaluation program administration standards. The competency evaluation may be administered by a nursing facility. The entity that administers
competency evaluations must meet the requirements of this section and must have the approval of the department:
(1) The written or oral examination must be administered by an individual with previous group testing experience;
(2) The skills demonstration must be administered by a registered nurse who has at least one year’s experience in providing care for the elderly or the chronically ill and who has taken a skills demonstration rater training course;
(3) The skills demonstration must be conducted in a nursing facility or laboratory setting comparable to the setting in which the nurse aide functions and must accommodate the number of nurse aides enrolled in the competency evaluation program.

44:04:18:19. Nursing facility proctoring of examination. The written, oral, or skills demonstration examination may be conducted in a nursing facility and proctored by facility personnel if the facility obtains department approval before giving the examinations. The nursing facility must ensure that the examination is secure from tampering. Department approval may be withdrawn if there is evidence of tampering. Scoring of the examination must be done by the professional testing company under contract with the department to administer the examination.

44:04:18:20. Notification to individual regarding successful or unsuccessful completion of the competency evaluation program. The facility offering the examination must advise in advance any individual who takes a competency evaluation that a record of the successful completion of the evaluation will be included in the registry. To be listed in the registry, a nurse aide must pass the written or oral portion and the skills demonstration portion of the competency evaluation with a score of at least 75 percent. If the nurse aide does not achieve a score of 75 percent, the facility must advise the nurse aide of the areas failed. The nurse aide may have two additional opportunities to complete evaluation successfully.

44:04:18:21. Operation of nurse aide registry. The department is accountable for the operation of the nurse aide registry and may designate an entity to maintain the registry. A nurse aide is listed on the registry through application or by endorsement. The department shall provide a copy of all information contained in the registry on an individual upon request. The public may contact the department at South Dakota Department of Health Office of Licensure and Certification 615 East 4th Street Pierre, South Dakota 57501 or by calling 605-773-3356 obtain information from the registry between the hours of 8:00 a.m. and 5:00 p.m. central time, Monday through Friday, except for state and federal holidays.

44:04:18:22. Registry status by application. A nurse aide seeking registry status must submit to the department an application, completed by the program coordinator or primary instructor, documenting successful completion of an approved training program. The entity responsible for scoring the nurse aide competency evaluation program must submit documentation of successful completion of the written or oral examination and the skills demonstration of the competency evaluation to the department within 30 days after the administration of the evaluation.

44:04:18:23. Registry status by endorsement. A nurse aide seeking registry status by
endorsement from another state registry must submit to the department the following information:
(1) A completed application;
(2) Written documentation indicating successful completion of another state’s approved nurse aide training and competency evaluation program;
(3) Verification of initial listing on the nurse aide registry in another state;
(4) Verification of listing on a nurse aide registry from the state of most recent employment; And
(5) Documentation of employment as a nurse aide within the last 24 consecutive months.

44:04:18:24. Registry content. The registry contains the following information for each nurse aide who has gained registry status:
(1) The full name of the nurse aide, including maiden name and any surnames used;
(2) The last known home address;
(3) The registration number;
(4) The date the registry status expires;
(5) The date of birth;
(6) The most recent employment;
(7) The date of successful completion of the examination and skills demonstration components of the competency evaluation;
(8) The name and address of the professional testing service that scored the competency evaluations taken by the nurse aide; and
(9) Any disciplinary proceedings against the nurse aide, including findings of abuse, neglect, or misappropriation of patient or resident property as specified in § 44:04:18:30.

44:04:18:25. Renewal of registry status. Registry status expires two years from the date of initial registration. To renew registry status, the nurse aide must submit to the department a verification of employment for a minimum of eight hours during the preceding 24 months. An individual who has not performed any nursing or nursing-related services for monetary compensation during the preceding 24 consecutive months must complete a new competency evaluation program.

44:04:18:26. Grounds for revocation, denial, or suspension of nurse aide registry status. The department may revoke a nurse aide's current registry status if the department determines after a contested case hearing pursuant to SDCL chapter 1-26 that the nurse aide has violated the meaning of abuse or neglect as those terms are defined in § 44:04:01:01. The department may deny registry status to a nurse aide applying for registration if the nurse aide was convicted of criminal charges related to abuse or neglect of an individual. Registry status may be suspended by the department during the investigation of an allegation of abuse or neglect by a nurse aide following due process as outlined in § 44:04:18:29.

44:04:18:27. Mandatory reporting of allegations. A nursing facility must notify the department in writing, within 48 hours, of any alleged misconduct by a nurse aide related to abuse or neglect of an individual or to misappropriation of a patient’s or resident’s property.
44:04:18:28. Investigation of allegations. After an allegation of abuse or neglect, the facility must take steps to prevent further incidents of abuse or neglect from occurring, investigate allegations thoroughly, and take any corrective action necessary. The facility must report its findings to the department within five working days. The department, or another agency of state government, may conduct its own investigation in addition to the facility’s investigation.

44:04:18:29. Notice and hearing process. The department shall follow the contested case procedure found in SDCL chapter 1-26 if a hearing is conducted:
(1) To determine if a nurse aide has engaged in abuse or neglect of an individual; or
(2) When the department denies a petition to remove a finding of neglect from the registry. If the department has determined abuse or neglect of an individual has occurred, a notice of the right to a hearing will be sent to the nurse aide. The notice shall state the aide has 10 days from receipt of the notice to respond. The notice shall include a waiver of hearing. Failure to return the waiver or failure to request a hearing within 10 days waives the right to a hearing.

44:04:18:30. Documentation of substantiated allegations on registry. If, after a hearing on the matter, the nurse aide is found to have committed abuse or neglect of an individual, the department shall update the registry with documentation within 60 days from the date of the ruling. If a waiver of hearing is received, the department shall update the registry by flagging the nurse aide's name on the registry. The documentation remains on the registry permanently and includes the following:
(1) A summary of the allegation;
(2) A summary of the department's investigative report;
(3) The statement by the nurse aide, if one is provided;
(4) The department's decision;
(5) The waiver of the hearing, if any; and
(6) A date of the hearing, findings of fact, and conclusions of law, and the outcome, if a hearing is held.

44:04:18:31. Procedure to remove of a finding of neglect from registry. A certified nurse aide may petition for a removal of a finding of neglect after one year beginning on the date on which the finding was placed on the certified nurse aide registry. If the department determines the employment and personal history of the certified nurse aide does not reflect a pattern of abusive behavior or neglect and the neglect in the original finding was a singular occurrence, the department may remove the finding from the registry. The department may deny the petition if the employment and personal history of the certified nurse aide reflects a pattern of abusive behavior or neglect and the neglect involved in the original finding was not a singular occurrence. The department shall follow the procedure as provided in § 44:04:18:29.