

.01 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Actual harm deficiency" means a condition existing in a nursing facility or an action or inaction by the nursing facility staff that has caused physical or emotional injury or impairment to a resident.

(1-1) "Administrator" means the individual licensed by the Board of Examiners of Nursing Home Administrators and responsible for the operation of the home.

(2) "Ambulatory patients" means those patients who are not dependent upon others for assistance to travel to safety in an emergency, including those patients who can ambulate independently with assistive devices.

(3) "Attending physician" means any person licensed to practice medicine in the State who admits patients to the facility with the understanding that he must comply with the facility's policies as developed by the patient care policy committee.

(4) "Audiologist" means a person who holds a current Maryland license issued by the Board of Audiologists, Hearing Aid Dealers, and Speech-Language Pathologists.

(4-1) "Authorized prescriber" has the meaning stated in Health Occupations Article, §12-101, Annotated Code of Maryland.

(5) "Certified social worker" means any person licensed to practice as a certified social worker in this State.

(5-1) "Charge nurse" means the registered or licensed practical nurse who is responsible for day-to-day operations of a unit in the facility on which residents live.

(5-2) "Communicable disease" means an acute illness or a chronic disease state of any of the agents causing these diseases:

- (a) Acquired immunodeficiency syndrome;
- (b) Amebiasis;
- (c) Cholera;
- (d) Conjunctivitis;
- (e) Diphtheria;
- (f) Hepatitis, viral (A, B, C, non-A, non-B, delta);
- (g) Human immunodeficiency virus (HIV) infection;
- (h) Salmonellosis;
- (i) Shigellosis;
- (j) Tuberculosis;
- (k) Typhoid fever; or
- (l) Evidence of any other condition as requested by the Secretary.

(5-3) "Comprehensive assessment" means the assessment that includes the Minimum Data Set and Resident Assessment Protocol Summary.

(6) "Comprehensive care facility" means a facility which admits patients suffering from disease or disabilities or advanced age, requiring medical service and nursing service rendered by or under the supervision of a registered nurse.

(6-1) "Concurrent review" means daily rounds by a licensed nurse which include:

(a) Appraisal and observation of all residents by the licensed nurse to determine any change in each resident's physical or mental status;

(b) If there is a change in the resident's physical or mental status, an evaluation by the licensed nurse of the resident's medications, laboratory values relating to the resident, and clinical data relating to the resident, including the resident's:

(i) Hydration and nutritional need;

(ii) Skin integrity;

(iii) Noted weight changes; and

(iv) Appetite;

(c) Evaluation of injuries sustained by the resident that result from accidents or incidents involving the resident; and

(d) Any other relevant parameters affecting or reflecting the resident's physical and mental status.

(7) "Deficiency" means a condition existing in a nursing facility or an action or inaction by the nursing facility staff that results in potential for more than minimal harm, actual harm, or serious and immediate threat to one or more residents.

(7-1) "Demonstration project" means a method of providing care and services to residents that does not comply with all the regulations in this chapter but provides sufficient safeguards to protect the health and safety of residents.

(8) "Dentist" means any person licensed to practice dentistry in this State.

(9) "Department" means the State Department of Health and Mental Hygiene.

(10) "Dietetic service supervisor" means a person who:

(a) Is a qualified dietitian;

(b) Is a graduate of a dietetic technician program approved by the American Dietetic Association;

(c) Is a certified dietary manager who has successfully completed the required course and maintains certification as required by the certifying board for the Dietary Managers Association;

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

(e) Has training and experience in food service supervision and management in a military service equivalent in content to §B(10)(b) and (d) in this regulation.

(11) "Discipline" means the medical, rehabilitative, nursing, dietetic, activities and social service components affiliated with the operation of a comprehensive care facility.

(12) "Extended care facility" means a facility which offers subacute care, providing treatment services for patients requiring inpatient care but who do not currently require continuous hospital services. A portion of a facility which is licensed as an extended care facility is called a distinct part extended care facility. This facility admits patients who require convalescent or restorative services, or rehabilitative services, or patients with terminal disease requiring maximal nursing care.

(13) "Fire authorities" means the official fire safety agency including the State Fire Marshal or local fire marshals or fire departments as appropriate.

(13-1) "Full assessment" means the Minimum Data Set without the Resident Assessment Protocol Summary.

(14) "Full time" means 40 hours per week or the standard work week adopted by the facility.

(15) "Geriatric nursing assistant" means a nurses' aide, patient care technician, orderly, attendant, or other supportive personnel assigned to the facility to perform patient care tasks under the direction and immediate supervision of a licensed nurse. The geriatric nursing assistant shall have successfully completed a geriatric nursing assistant training program approved by the Department.

(16) "Graduate social worker" means any person licensed to practice as a graduate social worker in this State.

(16-1) "Grant" means the award of money to an individual or an organization to:

(a) Study an aspect for the geriatric population; or

(b) Provide a service to nursing facility residents or their families.

(16-2) "Health care practitioner" means an individual who provides health care services and is licensed under the Health Occupations Article, Annotated Code of Maryland.

(16-3) "Health officer" means the health officer in each of the 23 counties and the Commissioner of Health in Baltimore City, or the designated representative of the health officer, or both.

(17) "Licensed practical nurse" means a person who holds a license to practice licensed practical nursing in this State.

(17-1) "Licensed or certified professional health care practitioner" means a nurse practitioner, physician assistant, or other practitioner licensed or certified under the Health Occupations Article, Annotated Code of Maryland.

(17-2) "Management firm" means an organization, under contract with an applicant for a license or a current licensee, that is intended to have or has full responsibility and control for the day-to-day operations of the nursing facility.

(18) "Mantoux tuberculin skin test" means a test to diagnose tuberculosis infection utilizing 5TU (tuberculin units) of purified protein derivative (PPD) that is injected intradermally and read within 48—72 hours with results recorded in millimeters of induration.

(18-1) "Maryland Monthly Assessment" means the assessment required by the Office of Access, Quality, and Program Integrity of the Department as an ongoing monitoring tool of the resident's status.

(19) "Medical director" means any person licensed to practice medicine in this State who, pursuant to a written agreement, is responsible for the overall coordination of the medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to patients and to maintain surveillance of the health status of employees.

(20) "Medicine aide" means a person who has successfully completed the 60-hour Department of Health and Mental Hygiene approved community college course and has further satisfied, where applicable, the continuing education requirements.

(20-1) "Minimum Data Assessment" means the Resident Assessment Instrument for Long Term Care Facilities, Transmittal No. 272, April 1995 and Transmittal No. 22, December 2000, U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services.

(20-2) "Minimum data set" means a core set of screening, clinical and functional status elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicare or Medicaid.

(20-3) "Minimum Data Set Quarterly Assessment" means the assessment that is completed on each resident not later than 92 days from the prior assessment.

(21) "New facility" means a comprehensive care facility or an extended care facility which does not have plans approved by the Department at the time of the adoption of these regulations. Any conversion, alteration, or additions which affect the facility's functional structure or bed capacity shall be constructed in accordance with these regulations, including the regulations which apply to "new facilities".

(22) "Nonambulatory patients" means those who are dependent upon others for assistance to travel to safety in an emergency and those persons who are unable to ambulate independently with assistive devices.

(23) "Nonrelated individual" has the meaning stated in Health-General Article, §19-301(k), Annotated Code of Maryland.

(23-1) "Nurse practitioner" has the meaning stated in Health Occupations Article, Title 8, Annotated Code of Maryland.

(24) "Nursing care" has the meaning stated in Health-General Article, §19-301(g), Annotated Code of Maryland.

(25) "Nursing facility" means a facility other than a facility offering domiciliary or personal care as defined in Health-General Article, Title 19, Subtitle 3, Annotated Code of Maryland, which offers nonacute inpatient care to patients suffering from a disease, condition, disability or advanced age, or terminal disease requiring maximal nursing care without continuous hospital services and who require medical services and nursing services rendered by or under the supervision of a licensed nurse together with convalescent services, restorative services, or rehabilitative services.

(26) "Occupational therapist" means a person who is currently certified by the American Occupational Therapy Association (AOTA) as a registered occupational therapist (OTR).

(27) "Occupational therapy assistant" means a person who is currently certified by the AOTA as an occupational therapy assistant.

(27-1) "Ongoing pattern" means the occurrence of any potential for more than minimal harm or greater deficiency on two consecutive on-site visits as a result of annual surveys, follow-up visits and unscheduled visits, or complaint investigations.

(28) "Other qualified person" means a person who is eligible for registration under the requirements set by the American Dietetic Association or has a baccalaureate degree with major studies in food and nutrition, dietetics, or food service management, has 1 year of supervisory experience in the dietetic service of a health care institution, and participates annually in continuing dietetic education.

(28-1) "Paid feeding assistant" means an individual who:

(a) Meets the requirements of Regulation .41E of this chapter; and

(b) Is paid by a facility to feed residents who are unable to perform the task themselves.

(29) "Patient" means "patient" as defined in Article 43, §556(g), Annotated Code of Maryland.

(30) "Patient activities consultant" means a person who is a qualified:

(a) Therapeutic recreation specialist;

(b) Occupational therapist; or

(c) Occupational therapy assistant.

(31) "Patient activities coordinator" means a person who:

(a) Is a qualified therapeutic recreation specialist;

(b) Is a qualified occupational therapist;

(c) Is an occupational therapy assistant; or

(d) Has 2 years of experience in a social or recreational program in a licensed health care setting within the last 5 years, 1 year of which was full time in a patient activities program with guidance from a qualified consultant in a health care setting.

(31-1) "Per instance civil money penalty" means a civil money penalty imposed for each deficiency.

(32) "Person" has the meaning stated in Health-General Article, §19-301(h), Annotated Code of Maryland.

(33) "Pharmacist" means any person licensed to practice pharmacy in this State.

(34) "Physical therapist" means any person licensed to practice physical therapy by the State Board of Physical Therapy Examiners.

(35) "Physical therapist assistant" means any person licensed as such by the State Board of Physical Therapy Examiners.

(36) "Physician" means any person licensed to practice medicine in this State.

(36-1) "Physician assistant" has the meaning stated in Health Occupations Article, Title 15, Annotated Code of Maryland.

(36-2) "Plan of correction" means a written response from the comprehensive or extended care facility addressing each deficiency cited as a result of an inspection by the Department.

(37) "Podiatric assistant" means any person registered as such by the State Board of Podiatry Examiners.

(38) "Podiatrist" means any person licensed by the State Board of Podiatry Medical Examiners.

(38-1) "Positive tuberculin skin test" means the presence of palpable induration of:

(a) 5 millimeters or more in diameter for individuals:

- (i) Known to have or suspected of having HIV infection,
- (ii) Who are close contacts of an individual with infectious tuberculosis disease,
- (iii) With X-ray or clinical evidence of active tuberculosis disease,
- (iv) Who have a chest radiograph suggestive of previous disease, or
- (v) Who have a history of injecting illicit drugs if HIV status is unknown; or

(b) 10 millimeters or more in diameter for:

- (i) All individuals not included in §B(38-1)(a) of this regulation,
- (ii) Risk groups that are defined in Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Facilities, 1994, Table S2-1, pages 62—63, which is incorporated by reference in Regulation .01-1 of this chapter, and
- (iii) Health care workers.

(38-2) "Potential for more than minimal harm deficiency" means a condition existing in a nursing facility or an action or inaction by the nursing facility staff that has the potential to cause actual harm to a resident.

(39) "Principal physician" means any person licensed to practice medicine in this State who agrees to perform certain medical services under contract with a comprehensive care facility, consistent with the policies of the facility.

(40) "PRN" means an abbreviation for the phrase "as circumstances may require".

(41) "Protective device" means any device or equipment, except bed side rails, which shields a patient from self-injury, or prevents a patient from aggravating an existing physical problem, or prevents a patient from precipitating a potential physical problem, and may limit, but does not eliminate, the movement of the patient's head, body, or limbs.

(42) "Psychologist" means a person who is certified by the State Board of Examiners of Psychologists to practice in this State.

(43) "Qualified medical record practitioner" means a person who:

- (a) Has received a baccalaureate degree from an accredited college or university including or supplemented by a successful completion of a course in health record administration approved by the Council on Medical Education of the American Medical Association, and has passed the national registration examination for registered record administrators; or
- (b) Possesses an associated arts degree in health record technology from a college or university approved by the American Medical Association Council on Medical Education or an equivalent approved health record technology correspondence course of the American Medical Record Association, and in addition has passed the national accreditation examination for accredited record technicians.

(44) "Qualified social work consultant" means any person who:

(a) Is a certified social worker; and

(b) Has a minimum of 3 years' experience in social work programs in a long-term care setting within the last 5 years.

(45) "Registered dietitian" means a dietitian who has met the certifying requirements for registration as administered by the Commission on Dietetic Registration, and who maintains the continuing education requirements of registration.

(46) "Registered nurse" means a person who holds a license to practice as a registered nurse in this State.

(46-1) "Representative" means an individual referenced in Regulation .08-1 of this chapter.

(46-2) "Resident Assessment Instrument (RAI)" means the total of the two parts of the document referred to as the MDS and the RAPS, which together are the model for resident assessment, decision-making (RAPS), care planning, care plan implementation, and evaluation.

(46-3) "Resident Assessment Protocol Summary (RAPS)" means the portion of the resident assessment instrument that is the problem-oriented framework for the decision-making process of care planning.

(47) "Restraint" means any physical or chemical restraint as defined below:

(a) "Physical restraint" means the use of force to prevent, suppress, or control head, body, or limb movement in a patient who is actively physically aggressive or combative or both in order to protect the patient from injuring himself or others;

(b) "Chemical restraint" means the administration of drugs with the intent of curtailing significantly the normal mobility or normal physical activity of a patient in order to protect the patient from injuring himself or others.

(48) "Secretary" means the Secretary of Health and Mental Hygiene.

(49) "Serious and immediate threat" means a situation in which immediate corrective action is necessary because a deficiency has caused or is likely to cause serious injury, harm, impairment to, or death of a resident receiving care in the nursing facility.

(49-1) "Significant change assessment" means an assessment that is completed on a resident who has demonstrated:

(a) Major changes in status that are not self limiting or which cannot be resolved within 14 days;

(b) A change in more than one area of the resident's health status which could demonstrate an improvement or decline in the resident's status; and

(c) The need for interdisciplinary review or revision of the care plan.

(50) "Social work associate" means any person licensed to practice as a social work associate in this State.

(50-1) "Special care unit" means a facility unit that provides intensive specialized care, such as respiratory, rehabilitative, dementia, or dialysis care, continuously on a 24-hour basis.

(51) "Speech pathologist" means a person licensed by the Board of Audiologists, Hearing Aid Dispensers, and Speech-Language Pathologists.

(52) "Supportive personnel" means an aide, assigned to a particular service such as nursing, dietary, physical therapy, or occupational therapy, who has been approved by the chief of the services as having sufficient training and experience to perform his assigned duties.

(52-1) "Sustained compliance" means a period of 30 calendar days following the date of notice of corrective action with no deficiencies.

(53) Tuberculosis in a Communicable Form.

(a) "Tuberculosis in a communicable form" means that an individual is presumed to have active pulmonary or laryngeal tuberculosis as evidenced by positive X-ray findings with or without positive acid-fast bacilli (AFB) sputum smear or positive AFB sputum culture and that the individual has been receiving chemotherapy for less than 14 days.

(b) "Tuberculosis in a communicable form" does not include:

(i) When the individual with presumed or confirmed active disease has had three negative AFB smears at least 24 hours apart, shows clinical improvement, and has received chemotherapy for at least 14 days; or

(ii) The individual with inactive scars, calcification, or a normal chest X-ray.

(54) "Tuberculosis suspect" means an individual who has a cough lasting more than 3 weeks and at least one other symptom that is compatible with active tuberculosis including bloody sputum, night sweats, weight loss, or fever.

(55) "Two-step tuberculin skin testing" means the administration of a second tuberculin skin test 1 to 3 weeks after the initial PPD is negative, to distinguish a boosted reaction from a reaction that is due to new infection.

.01-1 Incorporation by Reference.

A. In this chapter, the following documents are incorporated by reference.

B. Documents Incorporated.

(1) Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Facilities, 1994 (MMWR 1994; 43 No. RR-13; U.S. Centers for Disease Control and Prevention (CDC); Atlanta, Georgia).

(2) Immunization of Health-Care Workers: Recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC); (MMWR 1997; 46 No. RR-18; U.S. Centers for Disease Control and Prevention (CDC Atlanta, Georgia).

(3) Guideline for Infection Control in Health Care Personnel, 1998; Elizabeth A. Bolyard, Ofelia C. Tablan, Walter W. Williams, Michele L. Pearson, Craig N. Shapiro, Scott D. Deitchman and the Hospital Infection Control Practices Advisory Committee; (American Journal of Infection Control 1998; 26:289—354) and Infection Control and Hospital Epidemiology (1998; 19:407—63).

(4) Guideline for Isolation Precautions in Hospitals; Julia S. Garner and the Hospital Infection Control Practices Advisory Committee; (American Journal of Infection Control 1996; 24: (1); 37pp.)

.02 License Required.

A. A person may not establish, operate, or continue the operation of an existing comprehensive care facility or extended care facility without first obtaining a license from the Secretary. A license is valid for 2 years from the date of issuance, unless revoked by the Secretary.

B. Separate License Required. Separate licenses are required for facilities maintained on separate premises, even though they are operated under the same management. Separate licenses may be required for separate buildings on the same grounds.

C. Other License Required. A facility having a dual function, including care of the sick requiring hospital facilities in addition to rendering other care services, is required to be licensed for each level of health care rendered.

D. Posting of License Application and Instructions for Written Comment.

(1) At least 50 days before the anticipated date of the new license or relicensure, a facility shall conspicuously post:

- (a) Its application for initial license or license renewal; or
- (b) A notice describing where in the facility the application for licensure or relicensure may be found.

(2) The posting shall be near the entrance, in a manner which is plainly visible and easily read by the public.

(3) The posting shall include instructions for filing written comments to the Department.

E. Posting of License. A facility shall conspicuously post its license on the premises, at or near the entrance, in a manner which is plainly visible and easily read by the public.

F. Provisional License.

(1) The Secretary may issue a license to a comprehensive care facility or an extended care facility for less than a 24-month period under any of the following conditions:

(a) A facility has substantial deficiencies which in the opinion of the Department do not constitute a serious or immediate threat to the health, life, or safety of the residents and the facility has submitted a plan of correction to the Department which satisfactorily addresses the correction of each deficiency within a time frame acceptable to the Department;

(b) A facility has substantial deficiencies which in the opinion of the Department have no immediate adverse effect on the life, safety, or health status of residents but require construction or remodeling to correct, and the facility has made a bona fide commitment to correct the deficiencies by a required date;

(c) Departmental administrative delays have occurred which are beyond the control of the facility;

(d) If new construction is completed to the point of being able to provide all necessary services to its residents but certain substantial items of equipment of optional services, which in the opinion of the Department will have no immediate adverse effect on the safety or health of its residents, are lacking temporarily; or

(e) Licensing revocation proceedings are pending against the facility.

(2) A provisional license shall be based upon the facility's written plan of correction addressing every deficiency existing at the time of licensure, including specific corrective action with the anticipated date of correction for each deficiency. The Department's decision to issue a provisional license shall be based upon the reasonableness of the plan and the facility's compliance history.

(3) The Secretary shall issue only one license of less than 24 months during a given licensure period unless the facility can demonstrate that extenuating circumstances exist which are beyond the control of the facility in meeting a required deadline or, where necessary, to allow the Department to coordinate and unify its annual licensing dates with federal certification dates.

G. Waiver of Provisions. If a facility experiences practical difficulties or unnecessary hardships in complying with the

provisions of this chapter, and can demonstrate that granting a waiver will not adversely affect the health and safety of its residents, the Secretary may waive any provision of this chapter. A waiver granted to a facility is effective for the period specified in the waiver. A waiver may be revoked at any time if a facility violates a condition of the waiver or if it appears to the Secretary that the health or safety of residents residing in the facility would be adversely affected by the continuation of the waiver.

H. Plan of Correction Required.

(1) A facility shall submit a written plan of correction to the Department within 10 working days of the date that a facility receives written notice of deficiencies from the Department.

(2) The Department may not issue a license to a facility until the facility submits a plan of correction that is acceptable to the Department.

.03 Licensing Procedure.

A. Application for License.

(1) An applicant desiring to open a comprehensive care facility or an extended care facility or to continue the operation of an existing facility as a comprehensive care facility or an extended care facility shall file an application with the Secretary, on a form provided by the Secretary.

(2) A nonrefundable 2-year license fee shall accompany the application based on the following payment schedule:

(a) 1—50 beds: \$3,000;

(b) 51—99 beds: \$5,000;

(c) 100+ beds: \$7,000; and

(d) Transitional care units: \$600.

(3) An application for a license shall be filed with the Department at least 60 days before the anticipated issuance of the license.

(4) Applications on behalf of a legal entity shall be made by the senior officer or other senior official and a second official, if any.

(5) All members of the governing body shall be disclosed, with their business addresses.

(6) The applicant shall complete all disclosure required by the Secretary, including:

(a) Ownership of real property;

(b) The identity of any management company that will operate or contract with the applicant to operate the facility;

(c) Ownership of equipment; and

(d) The names of persons holding 5 percent or greater of stocks or assets.

(7) A facility that is a transitional care unit with fewer than 50 beds and that is affiliated with a licensed Maryland hospital shall pay the 2-year license fee for a transitional care unit.

(8) The applicant for a license to operate a comprehensive care facility or an extended care facility is the licensee. Responsibility for conformance with licensing standards and regulations rests upon the licensee. Those licensees requesting participation in the Maryland Medicaid program shall comply with the Medicaid contract.

(9) Additional Requirements.

(a) The Secretary shall require an applicant for licensure to submit to the Secretary the following information concerning the applicant's:

(i) Past or current operation of a nursing home, other health care facility as defined in Health-General Article, § 19-114, Annotated Code of Maryland, assisted living program, residential service agency or other licensed in-home care service, or licensed community program for individuals with developmental disabilities, substance abuse, or mental health needs, located within or outside this State;

(ii) Ability to comply with minimum standards of medical and nursing care and applicable State or federal laws and regulations by disclosing the identities of its medical director, director of nursing, and administrator, and by providing the facility's quality assurance plan, as required in Regulation .46 of this chapter; and

(iii) Financial and administrative ability to maintain a nursing home in compliance with these regulations, including

submission of an audited financial statement, whether or not the applicant ever operated a nursing home, related institution, or other health care facility.

(b) The Secretary shall:

(i) Approve the application unconditionally;

(ii) Approve the application with conditions, such as requiring the applicant to use the services of a management firm, requiring a staffing pattern, or limiting admissions to the facility; or

(iii) Deny the application.

(c) A party aggrieved by a decision of the Secretary under this section shall have the right to appeal as provided under the authority of Health-General Article, §2-207, Annotated Code of Maryland.

B. Restrictions of License.

(1) Nomenclature. Comprehensive care facilities or extended care facilities licensed under this regulation may not use in their title the word "Hospital".

(2) Zoning. If a proposed facility is to be located in a political subdivision requiring zoning approval, the zoning authority's written approval shall be submitted to the Department before the Department's approval of the first drawings which are submitted.

(3) Local Law or Ordinance, Where Applicable. Comprehensive care facilities or extended care facilities located in political subdivisions which require them to meet certain standards shall submit proof to the Secretary that they meet local laws, regulations, or ordinances at the time application for license is submitted.

(4) Renewal of License.

(a) A facility shall file an application to renew its license every 2 years at least 60 days before expiration of the issued license.

(b) The renewal application shall be:

(i) Submitted on forms provided by the Secretary; and

(ii) Accompanied by a nonrefundable 2-year license renewal fee based on the payment schedule in §A(2) of this regulation.

(5) A facility that is a transitional care unit with fewer than 50 beds and affiliated with a licensed Maryland hospital shall pay the 2-year license renewal fee for a transitional care unit.

(6) Transfer or Assignment of License. If the sale, transfer, assignment, or lease of a facility causes a change in the person or persons who control or operate the facility, the facility shall be considered a "new facility" and the licensee shall conform to all regulations applicable at the time of transfer of operations. The transfer of any stock which results in a change of the person or persons who control the facility, or a 25 percent or greater change in any form of ownership interest, constitutes a sale. For purposes of Life Safety Code enforcement, the facility is considered as an existing facility if it has been in continuous use as a nursing home. Waivers may be granted under Regulation .02F of this chapter.

(7) Return of License or Renewal Certificate to the Secretary of Health and Mental Hygiene. If the comprehensive care facility or the extended care facility is sold, leased, discontinued, the operation moved to a new location, the license revoked, or its renewal denied, the current license immediately shall become void and shall be returned to the Secretary.

.03-1 Licensed Bed Capacity.

A. A facility may exceed its licensed bed capacity only if the Department:

- (1) Requests that the facility exceed its licensed bed capacity; or
- (2) Approves a request from a facility to exceed its licensed bed capacity.

B. Departmental Request of Facility to Exceed Capacity. If the Department requests a facility to exceed its licensed bed capacity, the written request is to include the:

- (1) Circumstances that prompted the Department to make the request;
- (2) Conditions under which the licensed bed capacity may be exceeded; and
- (3) Number of residents by which the facility's licensed capacity may be exceeded.

C. Request for Departmental Permission to Exceed Capacity.

(1) If an emergency situation exists, a facility may request permission from the Department to exceed its licensed bed capacity to help resolve the emergency situation.

(2) The written request shall include the:

- (a) Circumstances or reasons for the request;
- (b) Identity of any resident involved;
- (c) Beginning and ending dates for which the request is made; and
- (d) Documentation of any objection by a resident affected by the request, or by the resident's personal representative.

(3) The facility shall:

- (a) Submit the written request to the Office of Licensing and Certification Programs; and
- (b) Be for a term not to exceed 30 days.

(4) Before reaching its decision on the request, the Department shall consider the:

- (a) Needs of the resident whose admission is proposed;
- (b) Ability of the facility to care for the resident properly;
- (c) Likely effect of the admission on the comfort and care of the other residents in the facility; and
- (d) Evidence that exceeding licensed capacity would help resolve the emergency situation.

(5) Required Resident Accommodations. Before a facility may admit a resident that causes the facility to exceed its licensed bed capacity, the facility shall:

- (a) Provide the following equipment for the exclusive use of the resident:
 - (i) Electronic nurses call system or hand bell,
 - (ii) Privacy curtain or screen,
 - (iii) Storage space for belongings, and

(iv) A bed, at least 36 inches wide, sturdy and in good repair;

(b) Meet any square footage requirements under this chapter for a room; and

(c) Meet any other condition that the Department may require.

(6) Admission. When a facility is permitted to exceed its licensed bed capacity under this section, the facility may not admit a resident to the facility until each resident admitted under permission granted under this section has:

(a) Been placed in the facility as part of the facility's permanent resident population; or

(b) Found other placement that is acceptable to the resident.

.04 Rights of Applicant if License Denied or Revoked.

A. Denial of License—Proposed Facility. The Secretary shall inform the applicant of the reasons for refusal to issue a license.

B. Revocation of License.

(1) The Secretary may, for cause shown, revoke or refuse to reissue any license issued by the Secretary. The Secretary shall consider the following factors in deciding whether a facility's license should be revoked:

(a) The number, nature, and seriousness of the deficiencies;

(b) The degree of risk to the residents posed by the deficiencies;

(c) The compliance history of the facility; and

(d) Background of the owner and management, including the owner's and management's experience in operating facilities and other businesses.

(2) The licensee shall have the right to a hearing before revocation of the facility's license. The hearing shall be held after 10 days notice to the licensee, and the licensee shall have an opportunity to be represented by counsel at the hearing.

.05 Inspection by Secretary of Health and Mental Hygiene.

A. Open at all Times for Inspection. Licensed comprehensive care facilities and extended care facilities and any premises proposed to be operated by an applicant for a license shall be open at all times to inspection by the Secretary and by any agency designated by the Secretary.

B. Records and Reports. Licensees shall keep such records and make reports in the manner and form as the Secretary shall prescribe and all these records and reports shall be open to inspection by the Secretary. Upon the written request of the Secretary or the Secretary's designee, the licensee shall provide immediately to the Secretary, photocopies of records and reports, including the clinical records of residents. The Department, upon request, shall reimburse the licensee for the cost of photocopying all records and reports requested under this section.

C. The Secretary shall have the authority to immediately restrict admissions in accordance with the provisions of Health-General Article, §19-328, Annotated Code of Maryland.

.06 New Construction, Conversion, Alteration, or Addition.

A. Submission of Plans. The plans review cycle normally will consist of a schematic phase, a design and development phase, and a final or construction phase. The applicant or his designated representative shall provide information as required in the plans review cycle.

B. Service Facilities. A system of water supply, plumbing, sewerage, electrical power, garbage or refuse disposal may not be installed or extended until complete plans and specifications have been submitted and approved in accordance with §A of this regulation.

.07 Administration and Resident Care.

A. Responsibility.

(1) The licensee shall be responsible for the overall conduct of the comprehensive care facility or extended care facility and for compliance with applicable laws and regulations.

(2) The administrator shall be responsible for the implementation and enforcement of all provisions of the Patient's Bill of Rights Regulations under COMAR 10.07.09.

B. Delegation to Administrator.

(1) The licensee, if not acting as an administrator, shall appoint as administrator a responsible person who is qualified by training and experience, and is licensed by the Board of Examiners of Nursing Home Administrators for the State. The administrator shall be responsible for the control of the operation on a 24-hour basis and shall serve full-time, except that an administrator may, with the Department's approval, serve on a less than full-time basis for a maximum of two nursing facilities, one of which shall have a licensed capacity of 35 beds or less.

(2) The Department shall consider the following factors when considering whether to approve an administrator to serve on a less than full-time basis:

- (a) Geographical location of the facilities;
- (b) Ownership of the facilities;
- (c) Organizational structure of the facilities;
- (d) Size of the facilities; and
- (e) Background and experience of the administrator.

C. Absence of Administrator. In the absence of the administrator, the facility at all times shall be under the direct and personal supervision of an experienced, trained, competent employee. When the director of nursing serves as relief for the administrator, he shall designate an experienced, qualified registered nurse to direct the nursing service. The relief director of nursing shall be freed from other responsibilities.

D. Excessive Absenteeism of Administrator. If the administrator is absent from the facility an excessive amount of time, and the Department determines that the director of nursing's absence from nursing service is having an adverse effect on patient care, the Department may require the designation of a specific registered nurse who shall be named the "assistant director of nursing". The Department shall be notified of the name of the assistant director of nursing. When the designee is replaced, the Department shall be notified of the name of the registered nurse filling the vacancy.

E. Character. The administrator shall be of good moral character, in good physical and mental health, and shall demonstrate a genuine interest in the well-being and welfare of patients in the facility.

F. Staffing.

(1) The administrator shall employ sufficient and satisfactory personnel as specified in this chapter to give adequate patient care and to do feeding, maintenance, cleaning, and housekeeping.

(2) A facility may request a "voluntary admissions ceiling" by submitting a written request to the Department to authorize a temporary restriction on patient admissions based upon anticipated bed usage. When the facility wishes to request that the restriction be removed, the request shall include the specific effective date and a statement that personnel staffing is sufficient to meet the State's requirements at the designated census figure. The Department shall approve the increase in beds within 72 hours following receipt of the facility's documentation that the required additional staff is "in place" to serve the increased number of beds. Management of the facility may not permit the patient census to exceed the admissions ceiling without prior approval from the Department.

(3) As requested by the Department, the administrator or his designee shall telephone the Department's central bed registry, advising the Department of:

- (a) The number of vacant licensed beds in the facility;
- (b) The levels of care of the beds reported vacant;
- (c) The types of patients who will be accepted—private, Medicare, or Medicaid.

G. Educational Program. An ongoing educational program shall be planned and conducted for the development and improvement of skills of all the facility's personnel, including training related to problems and needs of the aged, ill, and disabled. Records shall be maintained reflecting attendance, by name and title, and training content. In-service training shall include at least:

- (1) Prevention and control of infections;
- (2) Fire prevention programs and patient related safety procedures in emergency situations or conditions;
- (3) Accident prevention;
- (4) Confidentiality of patient information;
- (5) Preservation of patient dignity, including protection of the patient's privacy and personal and property rights;
- (6) Psychophysical and psychosocial needs of the aged ill;
- (7) Receipt by each employee of appropriate orientation to the facility and its policies, and to the employee's position and duties;
- (8) Approval by the Department of the orientation and training programs.

H. Employment Records. A written application shall be on file for each employee and shall contain:

- (1) Employee's social security number.
- (2) Home address.
- (3) Educational background.
- (4) Past employment with documentation that references have been considered by the facility. If the employee formerly worked in a nursing home, consideration shall be given to the record as it relates to abuse of patients, theft, and fires.
- (5) The licensure of personnel employed as registered or licensed practical nurses shall be verified by the facility.

I. Supportive Personnel. To support placement in a specific position, there shall be sufficient documentation in the employee's record reflecting his training and experience. In instances when an aide is to be assigned to a particular service such as dietary, physical therapy, or occupational therapy, the person in charge of the service shall be responsible for the evaluation and approval of the qualifications.

J. New Supportive Personnel. New supportive personnel shall be credited for 50 percent of their working time until the employee's orientation program, as approved by the Department, is completed. The person in charge of the service to which the employee is assigned shall have input into the contents of the orientation program. Policies for the orientation program shall include the number of hours of orientation required for the various levels of supportive personnel. Following the period of orientation the person responsible for the orientation program and the person in charge of the service shall indicate satisfactory completion of the orientation program of the employee. The responsible department's approval shall be in writing, signed by the appropriate department head whose license number, if applicable shall be recorded in the record. In new facilities the director of nursing and supervisors of the various services, dietary, housekeeping, rehabilitation, and social services, shall be responsible for orienting the new supportive personnel to the facility's policies and procedures and to the physical plant. There shall be a complete orientation for all the employees in life safety and disaster preparedness. The number of daily admissions of patients shall be controlled to allow sufficient time for on-the-job training. Before the opening of the facility all supportive personnel shall have a minimum of 2 days of orientation training.

K. Relief Personnel. Provision shall be made for qualified relief personnel during vacations or other relief periods.

L. Availability of Information. The administrator shall make available to the Secretary such information as may be requested to insure that the facility is meeting the requirements of these and other applicable regulations.

.07-1 Employee Training on Cognitive Impairment and Mental Illness.

A. The following employees shall receive a minimum of 8 hours of training on cognitive impairment and mental illness within the first 90 days of employment:

(1) Any employee who is licensed, certified, or registered under the Health Occupations Article, Annotated Code of Maryland; and

(2) Any employee whose job duties include assisting residents with activities of daily living.

B. The training on cognitive impairment and mental illness shall be designed to meet the specific needs of the facility's population as determined by the staff trainer, including the following as appropriate:

(1) An overview of the following:

(a) A description of normal aging and conditions causing cognitive impairment;

(b) A description of normal aging and conditions causing mental illness;

(c) Risk factors for cognitive impairment;

(d) Risk factors for mental illness;

(e) Health conditions that affect cognitive impairment;

(f) Health conditions that affect mental illness;

(g) Early identification and intervention for cognitive impairment;

(h) Early identification and intervention for mental illness; and

(i) Procedures for reporting cognitive, behavioral, and mood changes;

(2) Effective communication including:

(a) The effect of cognitive impairment on expressive and receptive communication;

(b) The effect of mental illness on expressive and receptive communication;

(c) Effective verbal, non-verbal, tone and volume of voice, and word choice techniques; and

(d) Environmental stimuli and influences on communication;

(3) Behavioral intervention including:

(a) Identifying and interpreting behavioral symptoms;

(b) Problem solving for appropriate intervention;

(c) Risk factors and safety precautions to protect the individual and other residents; and

(d) De-escalation techniques;

(4) Making activities meaningful including:

(a) Understanding the therapeutic role of activities;

(b) Creating opportunities for productive, leisure, and self-care activities; and

(c) Structuring the day;

(5) Staff and family interaction including:

- (a) Building a partnership for goal-directed care;
- (b) Understanding families needs; and
- (c) Effective communication between family and staff;

(6) End-of-life care including:

- (a) Pain management;
- (b) Providing comfort and dignity; and
- (c) Supporting the family; and

(7) Managing staff stress including:

- (a) Understanding the impact of stress on job performance, staff relations, and overall facility environment;
- (b) Identification of stress triggers;
- (c) Self-care skills;
- (d) De-escalation techniques; and
- (e) Devising support systems and action plans.

C. Employees who are not licensed, certified, or registered or who do not assist residents with activities of daily living shall receive a minimum of 2 hours of training on cognitive impairment and mental illness within the first 90 days of employment. The training shall include:

(1) An overview of the following:

- (a) A description of normal aging and conditions causing cognitive impairment;
- (b) A description of normal aging and conditions causing mental illness;
- (c) Risk factors for cognitive impairment;
- (d) Risk factors for mental illness;
- (e) Health conditions that affect cognitive impairment;
- (f) Health conditions that affect mental illness;
- (g) Early identification and intervention for cognitive impairment;
- (h) Early identification and intervention for mental illness; and
- (i) Procedures for reporting cognitive, behavioral, and mood changes;

(2) Effective communication including:

- (a) The effect of cognitive impairment on expressive and receptive communication;
- (b) The effect of mental illness on expressive and receptive communication;
- (c) Effective verbal, non-verbal, tone and volume of voice, and word choice techniques; and
- (d) Environmental stimuli and influences on communication; and

(3) Behavioral intervention including risk factors and safety precautions to protect the individual and other residents.

D. Ongoing training in cognitive impairment and mental illness shall be provided annually and consist of, at a minimum:

(1) 2 hours for employees who are licensed, certified, or registered under the Health Occupations Article, Annotated Code of Maryland, or who assist residents with activities of daily living; and

(2) 1 hour for all other employees.

E. The training that is described in this chapter may be provided through various means including:

(1) Classroom instruction;

(2) In-service training;

(3) Internet courses;

(4) Correspondence courses;

(5) Pre-recorded training; or

(6) Other training methods.

F. When the training method does not involve direct interaction between faculty and the participant, the facility shall make available to the participant during the training a trained individual to answer questions and respond to issues raised by the training.

.08 Admission and Discharge.

A. **Discrimination Prohibited.** A facility licensed under these regulations may not discriminate in admitting or providing care to an individual because of the race, color, national origin, or physical or mental handicap of the individual.

B. **Contract.** Before or at admission, a contract shall be executed by the administrator and patient, guardian, or responsible agency which is consistent with the requirements of Health-General Article, § 19-344, Annotated Code of Maryland, "Rights of Individuals".

C. **Registry.** Facilities shall maintain a permanent patient registry in which the name of each patient is entered in chronological order with the date and number of entry.

D. **Admission Record.** A copy of the clinical record, identification, and summary sheet described in Regulation .20B shall be used as an admission record.

E. **Notification of Responsible Persons When Patient Moves.** The administrator or the administrator's designee shall notify the private or public agency or relative responsible for the patient when the patient is transferred from the facility for any reason or at time of death. The attending physician shall also be notified.

F. **Restrictions on Admission and Retention of Patients.** Patients may not be admitted or retained if, in the judgment of the attending physician, they are:

- (1) Acutely ill and require medical, surgical, or nursing care beyond the capabilities of the facility; or
- (2) Dangerous to themselves or others.

G. **Admissions Procedures for Patients With Communicable Diseases.** The following procedures are to be used when admitting an individual with a communicable disease into a nursing facility:

(1) A facility may not deny admissions to, or involuntarily discharge, an individual solely because the individual has a communicable disease;

(2) Any facility that intends to accept an individual with a communicable disease shall notify the Department before admitting the individual; and

(3) The Secretary or a designee of the Secretary may prohibit a facility from accepting an individual with a communicable disease if it is determined that admitting the individual with a communicable disease could pose a risk to the health, safety, or welfare of any other resident or individual associated with the facility.

.08-1 Resident's Representative.

A. A comprehensive or extended care facility shall recognize the authority of:

- (1) A guardian of the person under Estates and Trusts Article, § 13-705, Annotated Code of Maryland;
- (2) A guardian of the property under Estates and Trusts Article, § 13-201, Annotated Code of Maryland;
- (3) An advanced directive that meets the requirements of Health-General Article, § 5-602, Annotated Code of Maryland;
- (4) A surrogate decision maker with authority under Health-General Article, § 5-605, Annotated Code of Maryland;
- (5) A power of attorney that meets the requirements of Estates and Trusts Article, § 13-601, Annotated Code of Maryland;
- (6) A representative payee or other similar fiduciary; or

(7) To the extent permitted by Maryland law, any other individual, if that individual was designated by a resident who was competent at the time of designation.

B. A facility shall require documentation or other appropriate verification of the authority of a resident's representative. A facility may not recognize the authority of a resident's representative if the representative attempts to exceed the authority:

- (1) Stated in the instrument that grants the representative authority; or
- (2) Established by State law.

C. A facility shall:

- (1) Document in the resident's record the name of the individual, if any, with authority identified in §A of this regulation; or
- (2) Include the documentation in the record.

.09 Resident Care Policies.

A. Written Policies. Comprehensive care facilities and extended care facilities shall develop written policies, consistent with these regulations, to govern the nursing care and related medical or other services they provide covering the following:

(1) Admission, transfer, and discharge policies including categories of patients accepted and not accepted by the facility, or those who are required to transfer to another level of care. The facility's admission policy shall include a statement as to whether or not medical assistance patients will be admitted and if admitted, under what circumstances.

(2) Physician services.

(3) Patients' rights.

(4) Nursing services.

(5) Dietetic services.

(6) Specialized rehabilitative services—occupational therapy services, physical therapy services, speech pathology and audiology services.

(7) Pharmaceutical services.

(8) Laboratory and radiologic services.

(9) Dental services.

(10) Social services.

(11) Patient activities.

(12) Clinical records.

(13) Reports and action required in unusual circumstances.

(14) Utilization review.

(15) Infection control.

(16) Tuberculosis Surveillance. All comprehensive care facilities and extended care facilities shall have written policies and procedures, acceptable to the Department, for tuberculosis surveillance of all residents. See Regulation .21G of this chapter for tuberculosis surveillance requirements.

(17) Disaster plan.

(18) Housekeeping services, pest control, and laundry.

(19) Patient care management.

B. The patient care policies shall be developed with the advice of the principal physician (or medical staff or medical director, if applicable), and at least one registered nurse. Policies shall be reviewed at least annually by a group of professional personnel including one or more physicians and one or more registered nurses. Written policies shall be kept current with the policies used to administer the facility. For reference purposes, copies of the patient care policies shall be readily available to all personnel responsible for patient care.

C. Policies and Procedures.

(1) Upon the request of the Secretary or the Secretary's designee, the facility's policies and procedures shall be made available to the Secretary for onsite review.

(2) The licensee shall submit to the Department any significant substantive changes to the policies and procedures which have occurred since review of the policies and procedures within 2 weeks of implementation of the changes.

D. Use of Protective Device or Devices.

(1) A written physician's order is required for the use of a protective device or devices. This order shall be in effect for a maximum of 60 days. If continuation of the use of a protective device or devices beyond 60 days is necessary, a new order shall be written by the physician and rewritten every 60 days.

(2) The physician's order shall contain the specific type of protective device or devices to be used.

(3) The physician's order shall reflect his or her reason for ordering a protective device or devices.

(4) A patient in a protective device or devices shall be observed periodically by personnel, to insure that the patient's health needs are met.

(5) A patient who is in a protective device or devices may not be left in the same postural position for more than 2 consecutive hours.

.10 Physician Services.

A. Responsibility for the Resident's Care. The attending physician shall:

(1) Assess a new admission in a timely manner, based on a facility-developed protocol, depending on:

- (a) The individual's medical stability;
- (b) Recent and previous medical history;
- (c) Presence of significant or previously unidentified medical conditions; or
- (d) Problems that cannot be handled readily by phone;

(2) Seek, provide, and analyze needed information regarding a resident's current status, recent history, and medications and treatments, to enable safe, effective continuing care and appropriate regulatory compliance;

(3) Provide appropriate information and documentation to support a facility-determined level of care for a new admission;

(4) Provide for the authorization of admission orders in a timely manner, based on a facility-developed protocol, to enable the nursing facility to provide safe, appropriate, and timely care; and

(5) For a resident who is to be transferred to the care of another health care practitioner, continue to provide all necessary medical care and services pending transfer until another physician has accepted responsibility for the resident.

B. Support Resident Discharges and Transfers. The attending physician shall:

(1) Follow-up as needed with a physician or another health care practitioner at a receiving hospital within 24 hours of the transfer of an acutely ill or unstable resident;

(2) Provide whatever summary or documentation may be needed at the time of transfer to enable care continuity at a receiving facility and to allow the nursing facility to meet its legal, regulatory, and clinical responsibilities for a discharged individual; and

(3) Provide a pertinent medical discharge summary within 30 days of discharge or transfer of the resident.

C. Periodic, Pertinent On-site Visits to Residents. The attending physician or licensed or certified professional health care practitioner shall:

(1) Visit a resident as frequently as the resident's condition requires, consistent with reasonable facility policies;

(2) Determine the progress of each resident's condition at the time of a visit by evaluating the resident, talking with staff as needed, and reviewing relevant information, as needed;

(3) Review and respond to issues requiring a physician's expertise, including:

- (a) The resident's current condition;
- (b) The status of any acute episodes of illness since the last visit;
- (c) Test results;

(d) Other actual or high-risk potential medical problems that may affect the individual's functional, physical, or cognitive status; and

(e) Staff, resident, or family questions regarding the individual's care and treatments; and

(4) At each visit, provide a legible progress note in a timely manner for placement on the chart, which includes relevant information about significant ongoing, active, or potential problems, including:

(a) Reasons for changing or maintaining current treatments or medications; and

(b) A plan to address relevant medical issues.

D. Timeliness of Visits and Progress Notes.

(1) Within 30 days of admission, a physician shall visit a resident, assess the resident's needs, and prescribe a regimen of medical care. After that, a physician, nurse practitioner, or physician assistant shall visit a resident every 30 days, except that a physician shall visit a resident at least every 120 days.

(2) The timeliness of visits shall be based on a facility-developed protocol, depending on:

(a) The resident's medical stability;

(b) Recent and previous medical history;

(c) The presence of significant or previously unidentified medical conditions; or

(d) Problems that cannot be handled readily by phone.

(3) The physician or licensed or certified professional health care practitioner shall maintain progress notes and make appropriate revisions to the resident's total program of care. The progress notes and revisions to the program of care shall cover, at a minimum, prognosis and changes in rehabilitation and other appropriate goals. The physician shall review and approve each program of care.

E. Alternate Schedule. If the physician determines that the resident's condition requires less frequent visits than described in §D of this regulation, the physician may order an alternate schedule in the resident's medical record. An alternate schedule may not be ordered for the resident's first 90 days of stay. The alternate schedule may not exceed 60 days between visits. If there is no alternate schedule approved by the physician, visits may not exceed 30-day intervals.

F. Adequate Ongoing Coverage. The attending physician shall:

(1) Designate an alternate physician or physicians who shall respond in an appropriate, timely manner if the attending physician is unavailable;

(2) Update the facility about the attending physician's current office address, phone, fax, and pager numbers to enable appropriate, timely communications, as well as the current office address, phone, fax, and pager numbers of designated alternate physicians;

(3) Help ensure that alternate physicians provide adequate, timely support while covering and intervene with alternate physicians when informed of problems regarding coverage; and

(4) Adequately inform alternate physicians about residents with active acute conditions or potential problems that may need medical follow-up during their on-call time.

G. Appropriate Care of Residents. The attending physician shall:

(1) Perform accurate, timely, and relevant medical assessments;

(2) Properly define and describe resident symptoms and problems, clarify and verify diagnoses, relate diagnoses to resident problems, and help establish a realistic prognosis and care goals;

(3) In consultation with the facility's staff:

(a) Determine appropriate services and programs for a resident, consistent with diagnoses, condition, prognosis, and resident wishes;

(b) Ensure that treatments are medically necessary and appropriate in accordance with nursing facility regulatory requirements; and

(c) Manage and document ethics issues consistent with relevant laws and regulations and with residents' wishes,

including advising residents and families about formulating advance directives or other care instructions and helping identify individuals for whom aggressive medical interventions may not be indicated;

(4) Respond in an appropriate time frame, based on a facility-developed protocol, to emergency and routine notification, to enable the facility to meet its clinical and regulatory obligations;

(5) Respond to notification of laboratory and other diagnostic test results in a timely manner, based on the resident's condition and clinical significance of the results;

(6) Analyze the significance of abnormal test results that may reflect important changes in the resident's status and explain the medical rationale for interventions or decisions not to intervene based on those results;

(7) Respond promptly to notification of, and assess and manage adequately, reported acute and other significant clinical condition changes in residents; and

(8) Ensure that individuals receiving palliative care have appropriate comfort and supportive care measures.

H. Appropriate, Timely Medical Orders. The attending physician shall:

(1) Provide timely medical orders based on an appropriate resident assessment, review of relevant pre-admission and post-admission information, and age-related and other pertinent risks of various medications and treatments;

(2) Provide sufficiently clear, legible written medication orders to avoid misinterpretation and potential medication errors, including:

(a) Medication strength and formulation, if alternate forms are available;

(b) Route of administration;

(c) Frequency and, if applicable, timing of administration; and

(d) Reason for which the medication is being given; and

(3) Institute safeguards to ensure the accuracy of verbal orders at the time the verbal orders are given and cosign the verbal orders in a timely fashion, but not later than the next visit to the resident.

I. Appropriate, Timely, and Pertinent Documentation. The attending physician shall:

(1) Provide documentation required to explain medical decisions, that promote effective care and allow a nursing facility to comply with relevant legal and regulatory requirements; and

(2) Complete death certificates in a timely fashion, including all information required of a physician.

.11 Medical Director Qualifications.

A. Medical Director Qualifications. The nursing facility shall:

(1) Designate a medical director who has at least the following qualifications:

(a) A current license as a physician in this State;

(b) At least 2 years of experience or specialized training in the medical care of geriatric or chronically ill and impaired residents;

(c) Successful completion of a curriculum in physician management or administration from the American Medical Directors Association or another curriculum approved by the Department or its designee; and

(d) Privileges at a hospital in this State, participant in an HMO network, or credentialed by a credentialing organization approved by the Department;

(2) Have a written agreement with a medical director that specifies the medical director's duties and roles and the authority to adequately discharge those responsibilities; and

(3) Submit a copy of the medical director's credentials to the Department upon:

(a) The first license renewal of the facility after the effective date of this regulation; and

(b) A change in medical director.

B. The requirement specified in §A(1)(c) of this regulation becomes effective 3 years after the effective date of this regulation, but the medical director shall begin the educational process in physician management or administration within the first year from the date of employment as a medical director.

.11-1 Medical Director Responsibilities.

A. General Responsibilities. The medical director is responsible for:

- (1) Overall coordination, execution, and monitoring of physician services;
- (2) Monitoring and evaluating the outcomes of the health care, including clinical and physician services provided to the facility's residents; and
- (3) Designating an alternate medical director with sufficient training and experience to perform the responsibilities of the medical director as described in the regulations of this chapter.

B. Practitioner Oversight. The medical director shall:

- (1) Oversee all physicians and other licensed or certified professional health care practitioners who provide health care to the facility's residents;
- (2) Ensure that there is a procedure for the review of the practitioners' credentials and the granting of privileges for licensed or certified professional health care practitioners who treat residents of the nursing facility; and
- (3) Recommend rules governing the performance of physicians and other licensed or certified professional health care practitioners who admit residents to the facility.

C. Defining the Scope of Medical Services.

- (1) The medical director, in collaboration with the facility, shall recommend written policies and procedures that are approved by the licensee, delineating the scope of physician services and medical care.
- (2) The facility shall make these policies and procedures available to a resident or resident's representative upon admission and whenever a substantive change is made.

D. Ensuring Physician Accountability. The medical director, in collaboration with the facility, shall recommend policies and procedures that cover essential physician responsibilities to the residents and the facility, including:

- (1) Accepting responsibility for the care of residents;
- (2) Supporting resident discharges and transfers;
- (3) Making periodic, pertinent resident visits in the facility;
- (4) Providing adequate ongoing medical coverage;
- (5) Providing appropriate resident care;
- (6) Providing appropriate, timely medical orders;
- (7) Providing appropriate, timely, and pertinent documentation;
- (8) Advising residents and families about formulating advance directives; and
- (9) Any other responsibilities as determined by the facility and the medical director.

E. Quality Assurance. The medical director shall actively participate in the facility's quality improvement process. Participation shall include:

- (1) Regular attendance at, and reporting to, the facility's quality improvement committee meetings; and
- (2) Routine participation in ongoing facility efforts to improve the overall quality of the clinical care, including facility efforts to evaluate and address the causes of various care-related problems and deficiencies cited by the Office of Health Care

Quality.

F. Employee Health Oversight. The facility, in consultation with the medical director and other physicians, if necessary, shall establish and maintain surveillance of the health status of employees, including:

(1) Advising on the development and execution of an employee health program, which shall include provisions for determining that employees are free of communicable diseases according to current acceptable standards of practice; and

(2) Ensuring that the facility plans and implements required immunization programs.

G. Other Related Duties. The medical director shall perform other essential duties related to clinical care and physician practices, including:

(1) Advising the administrator and the director of nursing on clinical issues, including the criteria for residents to be admitted, transferred, or discharged from the nursing facility;

(2) Working with the nursing facility to establish appropriate relationships with area hospitals and other pertinent institutions to improve care of the residents;

(3) Advising and consulting with the nursing facility staff regarding communicable diseases, infection control, and isolation procedures, and serving as a liaison with local health officials and public health agencies that have policies and programs that may affect the nursing facility's care and services to residents;

(4) Providing or arranging for temporary physician services as needed to ensure that each resident has continuous physician coverage;

(5) Participating as appropriate in facility committee projects and meetings concerning clinical care and quality improvement that require physician input; and

(6) Educating or overseeing the education of, and informing, all attending physicians about their roles, responsibilities, and applicable rules and regulations.

H. Medical Director Oversight Plan.

(1) Based upon physician and medical director responsibilities in nursing facilities, as described in this chapter, the medical director shall develop and implement a plan describing how the medical director will carry out the responsibilities for the:

(a) Overall monitoring, coordination, and execution of physician services and medical care to residents of the nursing facility; and

(b) Systematic review of the quality of health care, including medical and physician services, provided to the facility's residents.

(2) Minimum Requirements of the Plan. The medical director oversight plan shall include, at least, a plan to ensure that physicians:

(a) Accept appropriate responsibility for residents under the physicians' care in the nursing facility;

(b) Provide appropriate, timely medical care consistent with widely identified medical principles relevant to the facility's population; and

(c) Provide appropriate, timely, and pertinent medical documentation and orders.

(3) Documentation Regarding Medical Director Activities.

(a) The medical director shall keep documentation regarding the medical director's activities in relation to designated responsibilities.

(b) The documentation required in this subsection may include:

(i) Notes;

(ii) Minutes;

(iii) Copies of faxes, letters, and telephone communications with attending physicians, other facility staff and departments, the administration, the governing body, and others regarding concerns, inquiries, and interventions.

(c) The documentation required in this subsection shall show evidence of the medical director's interventions and follow-up of the effectiveness of those interventions.

I. Quality Assurance Committee Minutes. Committee minutes shall reflect monthly input from the medical director regarding physician issues and general facility clinical care issues.

.11-2 Facility's Responsibilities in Relation to the Facility's Medical Director.

A. The nursing facility shall:

- (1) Be responsible for working with the medical director to ensure adequate resident care and practitioner performance;
- (2) Inform the physician of explicit requirements as a medical director and assist the medical director in gaining the necessary information and tools to properly execute those responsibilities; and
- (3) Ensure that the medical director has the necessary support and authority to perform medical director duties effectively and to hold practitioners accountable.

B. When the attending physician and medical director document a resident's medical need for a particular treatment, assistive device, or equipment, that treatment, assistive device, or equipment shall be provided by the facility unless the facility documents in the quality assurance committee minutes the reason or reasons why the treatment, assistive device, or equipment should not be provided.

C. When the attending physician and medical director agree that a particular facility-developed protocol is required to ensure that quality medical care is delivered to the facility's residents, that protocol shall be implemented unless the facility documents in the facility's patient care committee minutes the reason or reasons why the protocol should not be implemented.

D. Evaluation of Medical Director's Performance.

- (1) The facility shall have a mechanism for evaluating the medical director's performance and for providing the medical director with feedback about that performance.
- (2) The criteria for evaluation shall be based on explicit medical director responsibilities and shall facilitate the medical director's improvement and performance of functions and duties.

.12 Nursing Services.

A. Organization, Policies, and Procedures. Nursing service shall provide the care appropriate to the patients' needs with the organizational plan, authority, functions, and duties clearly defined. Nurses and supportive personnel shall be chosen for their training, experience, and ability. Policies and procedures shall be adopted and made available to all nursing personnel.

B. Director of Nursing. The facility shall provide for an organized nursing service, under the direction of a full-time registered nurse except that a licensed practical nurse serving as director of nursing as of the effective date of these regulations may continue to serve as director of nursing in the comprehensive care facility in which employed. Upon departure of the licensed practical nurse, the successor shall be a registered nurse. If the director of nursing is a licensed practical nurse, there shall be sufficient hours of consultation with the licensed practical nurse from a registered nurse to assess and plan the patient care, to evaluate the outcomes of the services provided, and to initiate reassessment and replanning.

C. Signed Agreement.

(1) A signed copy of the agreement between the administrator and the director of nursing, showing the license number, shall be filed with the Department upon:

- (a) Application for an initial license; and
- (b) A change of director of nursing.

(2) The agreement shall specify the duties of the director of nursing.

D. Termination of Services of Director of Nursing. If the director of nursing terminates his services, the administrator immediately shall notify the Department of the termination. The name of the replacement and registration number shall be supplied to the Department as soon as the employment is effected. A copy of the agreement between the administrator and the replacement shall be sent to the Department.

E. Director of Nursing's Vacancy Exceeding 30 Days. If the position of director of nursing remains vacant for a period of 30 days, the license may be revoked unless the administrator and the governing body are able to demonstrate that they have made every effort to obtain a replacement.

F. Relief for Director of Nursing. When the director of nursing is absent, he shall designate an experienced, qualified registered nurse to direct the nursing service. In facilities in which the director of nursing serves as relief for the administrator, the director of nursing shall designate a specific registered nurse who shall be in charge of the nursing service. See Regulation .07C, of this regulation.

G. Responsibilities of the Director of Nursing. The responsibilities of the director of nursing shall include:

(1) Assisting in the development and updating of statements of nursing philosophy and objectives, defining the type of nursing care the facility shall provide;

(2) Preparation of written job descriptions for nursing personnel;

(3) Planning for the total nursing needs of patients to be met and recommending the assignment of a sufficient number of supervisory and supportive personnel for each tour of duty;

(4) Development and maintenance of nursing service policies and procedures to implement the program of care;

(5) Participation in the coordination of patient services through appropriate staff committee meetings (pharmacy, infection control, patient care policies, and utilization review) and departmental meetings;

(6) Cooperation with administration in planning the orientation program and the staff development program to upgrade the competency of the personnel;

(7) Ensurance that the philosophy and objectives are understood and practiced by nursing personnel;

(8) Participation in planning and budgeting for nursing services;

(9) Establishment of a procedure to ensure that nursing personnel, including private duty nurses, have valid and current Maryland licenses;

(10) Execution of patient care policies (unless delegated to principal physician, medical director);

(11) Participation in the selection of prospective admissions to ensure that facility's staff is capable of meeting the needs of all patients admitted;

(12) Coordination of the interdisciplinary patient care management efforts;

(13) Supervision of medicine aides to ensure that there is no deviation from the limitations and restrictions placed upon them.

H. Delegation of Responsibilities. If any of the above responsibilities are delegated to others, there shall be a clear delegation of authority.

I. Supervisory Personnel--Comprehensive Care Facilities.

(1) Comprehensive care facilities shall provide at least the following supervisory personnel:

Patients	Registered Nurses
(a) 2—99	One—full-time
(b) 100—199	Two—full-time
(c) 200—299	Three—full-time
(d) 300—399	Four—full-time

(2) The director of nursing is included in the above requirements.

J. Hours of Bedside Care—Comprehensive Care Facility. Comprehensive care facilities shall employ supervisory personnel and a sufficient number of supportive personnel, trained and experienced, or both, to provide a minimum of 2 hours of bedside care per licensed bed per day, 7 days per week. Bedside hours include the care provided by registered nurses, licensed practical nurses, and supportive personnel except that ward clerks' time shall be computed at 50 percent of the time provided in the nursing unit. Only those hours which the director of nursing spends in bedside care may be counted in the 2-hour minimal requirement. The director of nursing's time counted in bedside care shall be documented.

K. Exception for Facilities Which Do Not Participate in a Federal Program. Facilities with 40 or fewer beds which do not participate in a federal program may request the Department for an exception to the above staffing pattern. If in the public interest and there is no hazard to the patients, the Department may grant an exception based on information which includes the:

(1) Size of the facility;

(2) Geographic location of the facility;

(3) Admission policies of the facility;

(4) Existing staffing pattern of the facility;

(5) Number of volunteers in the activity program.

L. Staffing in Extended Care Facility. Extended care facilities shall be staffed with a registered nurse, 24 hours per day, 7 days per week. Additional registered nurses, licensed practical nurses, and supportive personnel shall be employed to meet the needs of all the patients admitted. The facility shall be staffed in accordance with guidelines established by the Department.

M. Staffing in Distinct Part Extended Care Facility. In multi-level facilities the director of nursing shall be in charge of the entire facility. A registered nurse at all times shall be in charge of a distinct part extended care facility. Additional registered nurses, licensed practical nurses, and supportive personnel shall be employed to meet the needs of all the patients admitted. The distinct part shall be staffed in accordance with guidelines established by the Department.

N. Nursing Service Personnel on Duty. The ratio of nursing service personnel on duty to patients may not at any time be less than one to 25, of fraction thereof.

O. Nursing Care—24 Hours a Day. There shall be sufficient licensed and supportive nursing service personnel on duty 24 hours a day to provide appropriate bedside care to assure that each patient:

- (1) Receives treatments, medications, and diet as prescribed;
- (2) Receives rehabilitative nursing care as needed;
- (3) Receives proper care to prevent decubitus ulcers and deformities;
- (4) Is kept comfortable, clean, and well-groomed;
- (5) Is protected from accident, injury, and infection;
- (6) Is encouraged, assisted, and trained in self-care and group activities.

P. Daily Rounds—Director of Nursing. Although daily rounds are primarily the responsibility of the charge nurse or nurses, the director or assistant director of nursing should make clinical rounds to nursing units, randomly reviewing clinical records, medication orders, patient care plans, staff assignments, and visiting patients. If indicated, the director or assistant director of nursing should accompany physicians visiting patients.

Q. Charge Nurse. At least one licensed nurse shall be on duty at all times and shall be designated by the director of nursing to be in charge of the nursing activities during each tour of duty. The charge nurse or nurses shall have the ability to recognize significant changes in the condition of patients and to take necessary action.

R. Charge Nurses' Daily Rounds. The charge nurse or nurses shall make daily rounds to all nursing units for which responsible, performing such functions as:

- (1) Visiting each patient;
- (2) Reviewing clinical records, medication orders, patient care plans, and staff assignments;
- (3) To the degree possible, accompanying physicians when visiting patients.

S. Program of Restorative Nursing Care. There shall be an active program of restorative nursing care aimed at assisting each patient to achieve and maintain his highest level of independent function including activities of daily living. This program shall include:

- (1) Ambulation and range of motion;
- (2) Maintaining good body alignment and proper positioning of bedfast patients;
- (3) Encouraging and assisting patients to change positions at least every 2 hours to stimulate circulation and prevent decubiti and deformities;
- (4) Encouraging and assisting patients to keep active and out of bed for reasonable periods of time, within the limitations permitted by physicians' orders, and encouraging patients to achieve independence in activities; and
- (5) Assisting patients to adjust to their disabilities, to use their prosthetic and assistive devices, and to redirect their interests, if

T. Coordination of Nursing and Dietetic Services. Nursing and dietetic services shall establish an effective policy to assure that:

- (1) Nursing personnel are aware of the nutritional needs and food and fluid intake of patients and ensure that special feedings and nourishment are provided when required;
- (2) Nursing personnel assist promptly when necessary in the feeding of patients;

- (3) The dietetic service is informed of physicians' diet orders and of patients' problems;
- (4) Food and fluid intake of patients is observed, and deviations from normal are recorded and reported to the:
 - (a) Charge nurse,
 - (b) Physician, and
 - (c) Dietetic service.

U. Inservice Educational Program. There shall be a continuing inservice educational program in effect for all nursing personnel in addition to a thorough job orientation for new personnel. There shall be documentation of content of programs and names and titles of participants. The program which shall be the responsibility of the director of nursing shall be approved by the Department.

V. Director of Nursing's Continuing Education. The director of nursing shall assume responsibility for maintaining his own professional competence through participation in programs of continuing education.

W. Responsibility to Report Care Which is Considered Questionable. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, the nurse shall call this to the attention of the supervisor who, in turn, shall, if indicated, refer the matter to the director of nursing services. If warranted, the director of nursing shall bring the matter to the attention of the principal physician or medical director, as applicable.

.13 Dietetic Services.

A. Services Provided. Services may be provided directly by the facility or the facility may contract with a food management company, a caterer, or another facility. The facility and the food management company (or caterer or facility providing service) shall comply with these regulations. Food service personnel shall comply with COMAR 10.15.03 Food Service Facilities.

B. Supervision.

(1) In facilities exceeding 50 beds, overall supervisory responsibilities for the dietetic service shall be assigned to a full-time qualified dietetic service supervisor. It shall be the responsibility of the supervisor to delegate relief duties to a person qualified to serve as relief. (See Supportive Personnel, Regulation .07J, of this chapter.)

(2) In facilities with 26—50 beds, exceptions may be made by the Department to allow the supervisor to share cooking responsibilities with the full-time cook.

(3) In facilities with 25 beds or fewer, responsibility may be assigned to the full-time cook.

(4) If a facility can demonstrate that because of the experience and training of its personnel and the physical layout and equipment, less supervisory personnel is required, the Department may modify the above requirements for supervision.

C. Consultation.

(1) If the supervisor is not a dietitian, the individual shall receive regularly scheduled consultation from a registered dietitian or other qualified person. In all instances sufficient consultation shall be provided to fulfill all required responsibilities.

(2) There shall be a signed agreement between the facility and the consultant dietitian specifying hours and frequency of service responsibilities, and registration number if applicable.

(3) Consultation services shall be documented by written reports.

D. Staffing.

(1) A sufficient number of food service personnel shall be employed to carry out efficiently the functions of the dietetic service and meet the dietary needs of the patient.

(2) Working hours shall be scheduled to insure that the dietetic needs of the patients are met.

(3) Nursing, housekeeping, laundry, or other personnel may not be utilized as dietetic staff. Exceptions may be made only upon the written approval of the Department. The kitchen may not be used for any purpose other than the preparation of food.

E. Adequacy of Diet. The food and nutritional needs of patients shall be met in accordance with physicians' orders. To the extent medically possible, the current "Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences", adjusted for age, sex, and activity shall be observed.

Agency Note: The "Diet Manual for Long-Term Care Patients" as published by the Department, which contains food allowances and guides for regular and therapeutic diets may be used.

F. Therapeutic Diets. Therapeutic diets shall be planned, prepared, and served as prescribed by the attending physician:

(1) Therapeutic diets shall be planned by a registered dietitian or other qualified person;

(2) Preparation and serving shall be supervised by a qualified dietetic supervisor;

(3) A current diet manual shall be available to medical, nursing, and dietetic staff.

G. Frequency and Quality of Meals. At least three meals or their equivalent shall be served daily, at regular times with not more than 14-hour intervals between the substantial evening meal and breakfast. A substantial evening meal is an offering of three or more menu items at one time, one of which includes a high quality protein such as meat, fish, eggs, or cheese. This meal

represents no less than 20 percent of the day's total nutritional requirements. To the extent medical orders permit, bedtime nourishments shall be offered routinely to all patients. If the four-or five-meal-a-day plan is used, the meal pattern to provide this plan shall be approved by the Department.

H. Advance Planning and Posting of Menus. Menus shall be written at least 1 week in advance. The current week's basic menu shall be posted in one or more easily accessible places in the dietetic service department and in the patient area.

I. Menus Served as Planned. Food sufficient to meet the nutritional needs of patients shall be prepared as planned for each meal. When menu changes are necessary, substitutions shall provide equal nutritional value.

J. Retention of Records. Menus as served and records of food purchased for consumption by patients shall be filed on the premises for a period of 30 days.

K. Preparation of Food. Foods shall be prepared by methods that conserve nutritive value, flavor, and appearance, and shall be served at proper temperatures, in a form to meet individual needs. Standardized recipes adjusted to appropriate yield shall be followed. Standardized recipes are those recipes which have been tested by the facility or another source which assure consistency in quality and quantity.

.14 Specialized Rehabilitative Services — Occupational Therapy Services, Physical Therapy Services, Speech Pathology and Audiology Services.

A. Rehabilitative Services—Admission Policies. In those facilities which do not accept patients in need of specialized rehabilitative services, the minimal acceptable restorative service shall be the restorative nursing care plan designed to maintain function or improve the patient's ability to carry out the activities of daily living as set forth in Regulation .12S, of this chapter, Program of Restorative Nursing Care.

B. Arrangements for Services. If a facility's admission policies include the admission of patients requiring rehabilitative services, the facility shall provide, or arrange for under written agreement, specialized rehabilitative services by qualified personnel (such as physical therapist, speech pathologist and audiologist, and occupational therapist). Initiation of services to meet the rehabilitative needs of the patient shall occur within 48 hours (excluding Saturday and Sunday) of the physician's order for the specialized service. The patient may not be accepted for admission if at least one service could not be initiated within the 48-hour period (excluding Saturday and Sunday).

C. Policies and Procedures. Written administrative and patient care policies and procedures shall be developed for rehabilitative services by appropriate rehabilitation team members and representatives of the medical, administrative, and nursing staff. Policies shall provide for the coordination of rehabilitative services and the rehabilitative aspects of nursing.

D. Written Plan of Care. Rehabilitative services shall be provided under a written plan of care, initiated by the attending physician, and developed in consultation with appropriate rehabilitation team members and the nursing service.

E. Physicians' Orders. Specialized rehabilitative services shall be provided only upon written orders of the attending physician. Orders shall include modalities to be used, frequency, and anticipated goals, and shall be made a part of the patient care plan. Unless medically contraindicated, the physician shall discuss with the patient or his family or sponsor the goals and the treatment program. The frequency of communications between the physician and the rehabilitation team members shall be governed by the status and changes in the patient and his medical status.

F. Progress Notes. Within 2 weeks of the referral to specialized rehabilitative services, the rehabilitation team members shall provide to the attending physician a written report of the evaluation, including goals and progress of the patient. Progress notes shall be written at least every 2 weeks.

G. Reevaluation of Patient's Progress. The physician and the rehabilitation team members shall reevaluate the patient's progress as necessary, but at least every 30 days. The physician may document on the record that his reevaluation may be less frequent but in no case may his reevaluation exceed 60 days. Appropriate action shall be taken.

H. Patient's Record. The physician's orders, the initial evaluations, the plan of rehabilitative care, goals, services rendered, evaluations of progress, and other pertinent information shall be recorded in the patient's medical record, and shall be dated and signed by the physician ordering the service and the person or persons who provided the service. The record and progress notes concerning the patient shall reflect at all times the most recent and current status of the patient, including current short-term and long-term goals.

I. Proof of Licensure. The facility shall maintain a file which includes proof of current licensure of all the rehabilitative services' personnel.

J. Job Descriptions. Current job descriptions for all rehabilitative services personnel shall be readily available in the facility.

.14-1 Special Care Units — General.

A. A facility which holds a current and valid operating license may establish special care units with the approval of the Office of Licensing and Certification Programs and the Department's Division of Engineering and Maintenance.

B. A facility may notify the Department of its intention to establish a special care unit before developing and submitting the required documents for approval as described in §C of this regulation.

C. The facility shall obtain Departmental approval of the following pertaining to the special care unit:

(1) A description and scope of services to be provided;

(2) An organization chart of the special care unit and its inter-relatedness to the rest of the nursing facility;

(3) A description of staffing patterns;

(4) Qualifications, duties, and responsibilities of personnel;

(5) A quality assurance plan which includes:

(a) Assignment of responsibility for monitoring and evaluation activities;

(b) Identification of the most important aspects of care provided;

(c) Identification of indicators and appropriate clinical criteria for monitoring the most important aspects of care;

(d) Establishment of thresholds (levels or trends) for the indicators that will trigger evaluation of care;

(e) Monitoring of the important aspects of care by collecting and organizing data for each indicator;

(f) Evaluation of care when thresholds are reached in order to identify opportunities to improve either care or problems;

(g) Taking actions to improve care or to correct the problems;

(h) Assessing the effectiveness of the actions, documenting the improvement in care, and assessing the quality assurance process; and

(i) Communication of the results of the monitoring and evaluation process to relevant individuals or services;

(6) Policies and procedures, including:

(a) The transfer or referral of residents who require services that are not provided by the special care unit;

(b) The administration of medicines unique to the needs of the special care residents;

(c) Infection control measures to minimize the transfer of infection in the special care unit;

(d) Pertinent safety practices, including the control of fire and mechanical hazards; and

(e) Preventive maintenance for equipment in the special care unit;

(7) Protocols for obtaining specialized services, such as arterial blood gases or other STAT services;

(8) Protocols for emergency situations; and

(9) An inventory of the specialized equipment to be housed in the unit to provide services in the special care unit.

D. A facility that has been approved to establish a special care unit shall meet all applicable requirements of this chapter.

E. Physician Coordinator.

(1) If the facility's medical director does not have special training and experience in the discipline of the assigned special care unit, the facility shall hire a physician who is appropriately trained and experienced to provide:

- (a) Overall medical supervision of the special care unit; and
- (b) Coordination of all services for the assigned special care unit.

(2) The facility shall verify the candidate's credentials before employment as physician coordinator.

(3) The physician coordinator, or a designee who meets the requirements of §E(1) of this regulation, shall:

(a) Respond personally or arrange for another qualified physician to respond to situations warranting medical intervention; and

(b) Be available to provide any required consultation.

F. Staffing. The facility shall ensure that each unit is sufficiently staffed with qualified personnel to provide appropriate treatment and special care needs of the residents.

G. Nursing Services.

(1) The director of nursing shall designate a registered nurse who has education, training, and experience in caring for the needs of the special care residents to coordinate all nursing care within the special care unit.

(2) Nursing staff shall be:

(a) Knowledgeable about the emotional and rehabilitative aspects of the special care unit residents; and

(b) Capable of initiating appropriate therapeutic interventions when needed.

H. Design.

(1) A special care unit shall meet the general construction requirements of Regulations .06 and .26 of this chapter, and the requirements in this regulation.

(2) The facility shall ensure that floor space allocated to each bed meets minimum requirements listed in Regulation .28C of this chapter, and is sufficient to accommodate the special equipment necessary to meet the needs of residents.

I. Radiologic and Laboratory Services. The facility shall ensure that diagnostic radiologic and clinical laboratory services are available 24 hours a day. The services may be provided through contractual arrangements with providers that meet applicable federal and State laws and regulations.

J. Quality Assurance Program. The facility shall:

(1) Develop a quality assurance plan to monitor and evaluate the care provided in each special care unit; and

(2) Monitor and evaluate the quality and appropriateness of care provided by the special care unit as part of the facility's overall quality assurance program.

.14-2 Special Care Units—Respiratory Care Unit.

A. A respiratory care unit shall meet the:

- (1) General requirements established for all special care units as outlined in Regulation .14-1 of this chapter; and
- (2) Requirements of this regulation.

B. The facility shall submit to the Department and obtain approval of the following:

- (1) All documents required in Regulation .14-1C of this chapter;
- (2) Policies and procedures for all aspects of care as outlined in Regulation .14-1C(6) of this chapter, and the following:

(a) Qualifications, duties, and responsibilities of staff, including the staff who are permitted to perform the following procedures:

- (i) Cardiopulmonary resuscitation;
 - (ii) Obtaining arterial blood gas samples and their analyses;
 - (iii) Pulmonary function testing;
 - (iv) Therapeutic percussion and vibration;
 - (v) Bronchopulmonary drainage;
 - (vi) Coughing and breathing exercises;
 - (vii) Mechanical ventilatory and oxygenation support for residents; and
 - (viii) Aerosol, humidification, and medical gas administration;
- (b) Weaning from mechanical ventilatory support and discharge planning for residents of the respiratory care unit; and
- (c) The procurement, handling, storage, and dispensing of medical gases.

C. Physician Coordinator. If the facility's medical director does not have special training and experience in diagnosing, treating, and assessing respiratory problems, the facility shall hire a physician who has the special knowledge and experience to provide:

- (1) Overall medical supervision of the respiratory care unit; and
- (2) Coordination of all services for the respiratory care unit.

D. Staffing. The facility shall ensure that:

- (1) Respiratory care services are provided by a sufficient number of qualified personnel;
- (2) Respiratory care personnel provide respiratory care services commensurate with their documented training, experience, and competence; and
- (3) As appropriate, respiratory care personnel are competent in the following:
 - (a) The fundamentals of cardiopulmonary physiology and of fluids and electrolytes;
 - (b) The recognition, interpretation, and recording of signs and symptoms of respiratory dysfunction and medication side effects, particularly those that require notification of a physician;

- (c) The initiation and maintenance of cardiopulmonary resuscitation and other related life-support procedures;
- (d) The mechanics of ventilation and ventilator function;
- (e) The principles of airway maintenance, including endotracheal and tracheostomy care;
- (f) The effective and safe use of equipment for administering oxygen and other therapeutic gases and for providing humidification, nebulization, and medication;
- (g) Pulmonary function testing and blood gas analysis, when these procedures are performed within the respiratory care unit;
- (h) Methods that assist in the removal of secretions from the bronchial tree, such as hydration, breathing and coughing exercises, postural drainage, therapeutic percussion and vibration, and mechanical clearing of the airway through proper suctioning technique;
- (i) Procedures and observations to be followed during and after extubation; and
- (j) Recognition of and attention to the psychosocial needs of residents and their families.

E. Design.

(1) Emergency Power. The facility unit shall meet all applicable requirements in Regulation .26F of this chapter for emergency electrical power, including the provision of:

- (a) Emergency lighting in the respiratory care unit where life support equipment is used; and
- (b) Duplex receptacles connected to the facility's emergency generator to provide emergency power to operate life support equipment and nonflammable medical gas systems in the respiratory care unit.

(2) Ventilator Alarms. The facility shall ensure that each ventilator is equipped with an alarm on both the pressure valve and the volume valve for safety.

F. The facility shall provide pulmonary function testing, and blood gas or pulse analysis capability onsite or through contractual arrangements with providers who meet applicable State and federal laws and regulations.

G. Contractual Services. When any respiratory care services are provided by an outside contractor, the facility shall:

- (1) Approve the contractor based on the contractor's credentials, training, and experience;
- (2) Ensure that all contractors:
 - (a) Provide services 24 hours a day;
 - (b) Meet all safety requirements;
 - (c) Abide by all pertinent policies and procedures of the facility;
 - (d) Provide services in accordance with all laws and regulations governing the facility; and
 - (e) Participate in the monitoring and evaluation of the appropriateness of services provided as required by the facility's quality assurance program; and
- (3) Ensure that all contractual services receive overall medical supervision and coordination by the facility's physician coordinator of the respiratory care unit.

.15 Pharmaceutical Services.

A. Facility Responsible for Pharmacy Services. The facility shall provide appropriate methods and procedures for administering drugs and biologicals. The facility shall be responsible for providing drugs and biologicals for its patients. Pharmaceutical services shall be provided in accordance with accepted professional principles and appropriate federal, State, and local laws. Any regulation in this chapter shall govern if higher.

B. Composition of Pharmaceutical Services Committee.

(1) A pharmaceutical services committee (or its equivalent) shall develop written policies and procedures for safe and effective drug therapy, distribution, control, and use. The composition of the committee shall include at least:

- (a) The pharmacist;
- (b) The director of nursing services;
- (c) The consultant dietitian;
- (d) One physician;
- (e) The administrator.

(2) All members of the committee are not required to be present at all meetings. The participation of members at a specific meeting shall be controlled by the agenda items to be discussed.

(3) Policies and procedures developed by the pharmaceutical services committee may not prohibit or restrict a resident from receiving medications from the pharmacy of the resident's choice except that, when the cost of any medication obtained from the pharmacy selected by the resident exceeds the cost of the same or equivalent medication available through a pharmacy that the facility has contracted with to provide pharmaceutical services, the resident shall be responsible for the excess amount. The committee may not require the pharmacy to provide drugs by way of a specific drug distribution system such as unit dose or utilization of a particular packaging system.

C. Duties of Pharmaceutical Services Committee. Unless the Department decides that semiannual meetings are appropriate, the committee shall meet at least quarterly to:

(1) Establish policies and procedures which shall include, at least, statements which assure that:

- (a) Medications, legend and non-legend, administered to patients shall be ordered in writing by the patient's physician.
- (b) Medications shall be administered by appropriately licensed personnel in accordance with laws and regulations governing these acts or by certified graduates of a State-approved medication aide course.
- (c) The person who prepares medications shall give and record them.
- (d) Medicine may not be returned to the container. If the patient refuses the drug or a mistake occurs, the drug shall be discarded and an annotation entered on the patient's chart. For unit dose policy see §E of this Regulation.
- (e) Nurses may not package, repackage, bottle, or label in whole or in part any medication, or alter in any way by tampering or defacing any labeled medication.
- (f) Medications not specifically limited as to time or number of doses, when ordered, shall be automatically stopped in accordance with the written policy originated by the committee.
- (g) Before invoking stop order policies, the patient's attending physician shall be contacted for instructions so that continuity of the patient's therapeutic regimen is not interrupted.

(h) Medications shall be accurately and plainly labeled. Except for those over-the-counter medications which the Department may list as suitable for purchasing in bulk and dispensing as needed, the labels for all medications shall bear at

least:

- (i) The patient's full name;
- (ii) The name of the drug;
- (iii) Potency;
- (iv) Original filling date and date refilled, if applicable;
- (v) Name of prescribing physician;
- (vi) Expiration date of medication (month, year);
- (vii) Appropriate special handling instructions regarding special storage;
- (viii) Name and address of dispensing pharmacy;
- (ix) Serial number;
- (x) Number of tablets or capsules;
- (xi) Accessory federal labels.

(i) Medications shall be stored in a locked medication storage area provided at, or convenient to, the nurses' station, which:

- (i) Is well lighted;
- (ii) is located where personnel preparing drugs for administration will not be interrupted;
- (iii) Is sufficiently spacious to allow storage of external medications separately from internal medications;
- (iv) Is kept in a clean, orderly and uncluttered manner; and
- (v) Contains a refrigerator if medications are to be maintained in it.

(j) Poisons and medications marked "for external use only" shall be kept separate from general medications and Schedule II drugs.

(k) Schedule II drugs shall be kept in separately locked, securely fixed boxes or drawers in the storage area, under two locks. The lock on the door of a medication room shall be counted as one of the two locks.

(l) Facilities which administer Schedule II Drugs shall maintain a drug record in which is recorded:

- (i) The name of the patient, the date, time, kind, dosage, and method of administration of all Schedule II Drugs;
- (ii) The name of the physician who prescribed the medication;
- (iii) The name of the nurse or medicine aide who administered the medication.

(m) Each facility, whether or not operating a licensed pharmacy, shall maintain a record and signed Schedule II count at each change of shift.

(n) Two members of the nursing home staff (administrator or nurse) may destroy controlled dangerous substances in Schedules II—V on the premises of the nursing home. In addition to any other required records, a record of the disposal shall be maintained in the facility. A copy of the record of disposal shall be forwarded to the Division of Drug Control.

(o) All medications written on prescription for patients who have left the institution shall be destroyed in the presence of an authorized representative of the Department or two witnesses, authorized by the facility, who shall sign a notation on the patient's chart. Any adulterated, deteriorated, or out-dated medications shall be destroyed in the presence of an authorized representative of the Department or two witnesses, authorized by the facility, who shall sign an appropriate record of the

action.

(p) Medications shall be released to patients on a discharge only basis with the written authorization of the patient's physician.

(2) Establish the contents of sealed, emergency drug kits. A sealed kit shall be kept readily available in each nurses' station. A list of contents, with expiration dates, shall be attached to the kit. The kits shall be of durable construction and easily cleaned.

(3) Oversee the pharmaceutical service to the facility to ensure accuracy and adequacy.

(4) Make recommendations for improvements.

(5) Document actions and recommendations.

D. The pharmacist, or his agent, shall be responsible for delivering medications to the facility. Members of the patient's family or the sponsor for the patient may not deliver medications to the patient or to the facility.

E. Pharmacist Supervises Services. If the facility does not employ a licensed pharmacist, it shall arrange for, by written contract, a licensed pharmacist to provide consultation on the administering of the pharmacy services in accordance with the policies and procedures established by the pharmaceutical services committee. The pharmaceutical services shall be under the general supervision of a qualified pharmacist who shall:

(1) Be responsible, with the advice of the pharmaceutical services committee, to develop, coordinate, and supervise the pharmaceutical services and provide in-service at least twice yearly.

(2) Visit the facility frequently enough to assure that policies and procedures established by the pharmaceutical services committee are enforced.

(3) If a patient desires to designate a particular pharmacy to provide his drugs, he shall inform the pharmacist that he must conform with the facility's written policies concerning the provision of drugs. If the pharmacist agrees to comply with the facility's policies, the patient may request that the consenting pharmacist perform the service. If the pharmacist fails to comply with the policies, a representative of the facility shall discuss with the patient the policy infractions. If after being informed of the infractions the pharmacist then refuses to cooperate, the patient shall select another pharmacist who will agree to comply with the facility's policies. Providers of drugs, pharmacists, shall have access to a copy of the written patient care policies.

(4) Arrange for pharmacies which provide medications for patients in the facility to agree, in a written agreement with the facility, to maintain at the pharmacy a patient profile record system for each patient in the facility for whom prescriptions are dispensed.

(5) At least monthly, review at the facility the individual patient records, performing a drug regimen review, and document the findings in the patient's medical record.

(6) Bring to the attention of the attending physician any potential drug problems found during the drug regimen review.

(7) At least quarterly, submit a report to the pharmaceutical services committee on the status of the facility's pharmaceutical service and staff performance.

F. Unit Dose System. A facility, before installing a unit dose system which has not been approved by the Office of Health Care Quality, shall obtain this approval before installing the system. Prior approval is not required for a system which has been approved unless the facility plans to make substantial changes in the system. Departmental approval of the unit dose system indicates compliance with these regulations.

G. Administration of Medications for Leave of Absence of 24 Hours or Less.

(1) A facility shall develop policies and procedures to ensure that a resident or, if the resident lacks capacity, the resident's family or other person accompanying the resident is informed, both orally and in writing, on how the resident must safely and correctly take the resident's medications during a short-term leave of absence of 24 hours or less.

(2) A licensed nurse shall prepare, in accordance with a facility-developed procedure, medications to be sent with a

resident on short-term leave from the facility of 24 hours or less.

.16 Laboratory and Radiologic Services.

A. Approved Source. Laboratory services provided by the facility shall meet the applicable conditions established under COMAR 10.10.01 Medical Laboratories in Maryland.

B. Provisions of Services. If the facility does not provide laboratory and radiologic services, arrangements shall be made for obtaining these services from a physician's office, a licensed laboratory in a hospital or nursing facility, a licensed independent laboratory, or a State-approved portable X-ray supplier.

C. Physician's Order Required. All services shall be provided only on the orders of the attending physician.

D. Reports of Findings. The attending physician shall be notified promptly of the findings. Signed and dated reports of diagnostic services shall be filed with the patient's medical record.

E. Transportation. The facility shall assist the patient, if necessary, in arranging for transportation to and from the source of service.

F. Blood and Blood Products—Blood Handling and Storage. Blood handling and storage facilities shall be safe, adequate, and properly supervised.

G. Storage and Transfusion. If the facility provides for maintaining and transfusing blood and blood products, it shall meet the standards in COMAR 10.10.02 Blood Banks.

H. Transfusion Services. If the facility does not provide its own facilities but does provide transfusion services alone, it shall meet at least the requirements in Regulation .09F—H under COMAR 10.10.02.

.17 Dental Services.

A. Provision for Dental Care. Patients shall be assisted to obtain routine and emergency dental care.

B. Advisory Dentist. There shall be an advisory dentist, licensed to practice in the State, who shall:

(1) Recommend oral hygiene policies and practices for the care of the patients and for arrangements for emergency treatment;

(2) Assist in the formulation of dental health policies;

(3) Provide direction for in-service training to give the nursing staff an understanding of patients' dental problems.

C. Assistance by Nursing Personnel. Nursing personnel shall assist the patient in carrying out routine dental hygiene.

D. Arrangements for Dental Service. If dental services are not provided on the premises, there shall be a cooperative agreement with a dental service.

E. Transportation. Arrangements shall be made, when necessary, for the patient to be transported to the dentist's office.

.18 Social Work Services.

A. Services Provided. The facility shall provide or make arrangements for services to identify and meet the patient's medically related social and emotional needs.

B. Designated Staff Responsibility. A member of the facility's staff shall be assigned responsibility for social services. If the designee is not a certified social worker, the facility shall effect an agreement with a qualified social work consultant. The agreement shall provide for sufficient hours of consultation to assure that the staff's services meet the medically related social and emotional needs of the patients.

C. Social History. The written social history shall be initiated within 7 days after admission. The history shall be as complete as possible and shall include:

(1) Social data about personal and family background to provide understanding of the patient and how he functions; and

(2) Information regarding current personal and family circumstances and attitudes as they relate to patient's illness and care.

D. Records. Records shall include:

(1) Social history; and

(2) Recommendations made by the social work consultant, if applicable.

E. Space. Facilities shall provide:

(1) Space for social work personnel, accessible to patients, medical, and other staff;

(2) Privacy for interviews.

.19 Patient Activities.

A. **Activities Program.** The facility shall provide for a program of structured and unstructured activities, designed and monitored appropriately to meet the day-to-day needs and interests of each patient, to encourage self-care, resumption of normal activities, and maintenance of an optional level of psychosocial functioning.

B. **Staffing.** A staff member qualified by experience or training shall be appointed to be responsible for the activities program. If the designee is not a qualified patient activities coordinator as defined in Regulation .01Y, of this chapter, the Department may approve the designee based on the person's education, performance, and experience.

C. If the Department determines that an effective program is not maintained consultation may be required as specified by the Department.

D. **Restrictions on Participation Documented on Chart.** The physician shall note on the patient's chart any restrictions applicable to the patient's participation in the activities program.

E. **Objective.** The activities shall be designed to promote the general health, physical, social, and mental well-being of the patients.

F. **Space, Supplies.** Adequate space and a variety of supplies and equipment shall be provided by the facility to satisfy the appropriate individual activity needs of patients.

.20 Clinical Records.

A. Records for all Patients. Records for all patients shall be maintained in accordance with accepted professional standards and practices.

B. Contents of Record. Contents of record shall be:

(1) Identification and summary sheet or sheets including patient's name, social security number, armed forces status, citizenship, marital status, age, sex, home address, and religion;

(2) Names, addresses, and telephone numbers of referral agencies (including hospital from which admitted), personal physician, dentist, parents' names or next of kin, or authorized representative;

(3) Documented evidence of assessment of the needs of the patient, of establishment of an appropriate plan of initial and ongoing treatment, and of the care and services provided;

(4) Authentication of hospital diagnoses (discharge summary, report from patient's attending physician, or transfer form);

(5) Consent forms when required (such as consent for administering investigational drugs, for burial arrangements made in advance, for release of medical record information, for handling of finances);

(6) Medical and social history of patient;

(7) Report of physical examination;

(8) Diagnostic and therapeutic orders;

(9) Consultation reports;

(10) Observations and progress notes;

(11) Reports of medication administration, treatments, and clinical findings;

(12) Discharge summary including final diagnosis and prognosis;

(13) Discipline assessment; and

(14) Interdisciplinary care plan.

C. Staffing. An employee of the facility shall be designated as the person responsible for the overall supervision of the medical record service. There shall be sufficient supportive staff to accomplish all medical record functions.

D. Consultation. If the medical record supervisor is not a qualified medical record practitioner, the Department may require that the supervisor receive consultation from a person so qualified.

E. Completion of Records and Centralization of Reports. Current medical records and those of discharged patients shall be completed promptly. All clinical information pertaining to a patient's stay shall be centralized in the patient's medical record.

F. Retention and Preservation of Records. Medical records shall be retained for a period of not less than 5 years from the date of discharge or, in the case of a minor, 3 years after the patient becomes of age or 5 years, whichever is longer.

G. Current Records—Location and Facilities. The facility shall maintain adequate space and equipment, conveniently located, to provide for efficient processing of medical records (reviewing, indexing, filing, and prompt retrieval).

H. Closed or Inactive Records. Closed or inactive records shall be filed and stored in a safe place (free from fire hazards) which provides for confidentiality and, when necessary, retrieval.

.21 Infection Control Program.

A. Infection Control Program. The facility shall establish, maintain, and implement an effective infection control program that:

(1) Investigates, controls, and prevents infections in a timely manner through a system that enables the facility to:

(a) Analyze patterns of infected individuals;

(b) Analyze changes in prevalent organisms;

(c) Analyze increases in the rate of infection; and

(d) Obtain surveillance data for the prevention and control of additional cases;

(2) Determines the procedures, such as appropriate precautions, that are to be applied to an individual resident;

(3) Maintains a record of infections in the facility, and the corrective actions that were taken related to infections; and

(4) Monitors and evaluates the:

(a) Effectiveness of the infection control program by surveying rates of infection, especially of those residents who have an especially high risk of infection; and

(b) Effective implementation of the policies and procedures that are outlined in §F(1) of this regulation.

B. The facility shall assign at least one individual with education and training in infection surveillance, prevention, and control to be responsible for approving actions to prevent and control infections.

C. Effective January 1, 2005, the facility's infection control coordinator shall attend a basic infection control training course that is approved by the Office of Health Care Quality and the Office of Epidemiology and Disease Control Program for the Department.

D. The facility shall have mechanisms for communicating the results of infection control activities to employees, and the individual or individuals who are responsible for improving the facility's performance.

E. The facility's communication mechanism shall ensure that the administrator, director of nursing, and the medical director receive and address reports of infection control findings and recommendations in a timely manner.

F. Infection Control Policies and Procedures.

(1) The infection control program shall establish written policies and procedures to investigate, control, and prevent infections in the facility including policies and procedures to:

(a) Identify facility-associated infections and communicable diseases in accordance with COMAR 10.06.01;

(b) Report occurrences of certain communicable diseases and outbreaks of communicable diseases to the local health department in accordance with COMAR 10.06.01 and Health-General Article, §18-202, Annotated Code of Maryland;

(c) Institute appropriate infection control steps when an infection is suspected or identified in order to control infection and prevent spread to other residents;

(d) Perform surveillance of residents and employees at appropriate intervals to monitor and investigate causes of infection, facility-associated and community acquired, and the manner in which it was spread;

(e) Train employees about infection control and hygiene including:

(i) Hand hygiene;

(ii) Respiratory protection;

(iii) Soiled laundry and linen processing;

(iv) Needles, sharps, or both;

(v) Special medical waste handling and disposal; and

(vi) Appropriate use of antiseptics and disinfectants.

(f) Train and monitor employee application of infection control and aseptic techniques; and

(g) Review the infection control program at least annually and revise as necessary.

(2) The facility shall provide information concerning the communicable disease status of any resident being transferred or discharged to any other facility, including a funeral home.

(3) The facility shall obtain information concerning the communicable disease status of any resident being transferred or discharged to the facility.

G. Preventing Spread of Infection.

(1) The facility shall assess any residents with signs and symptoms of an infectious illness for the possibility of transmission to another resident or employee.

(2) The facility shall take appropriate infection control steps to prevent the transmission of a communicable disease to residents, employees, and visitors as outlined in the following guidelines:

(a) Guideline for Isolation Precautions in Hospitals; and

(b) Guideline for Infection Control in Health Care Personnel.

(3) The facility shall prohibit employees with a communicable disease or with infected skin lesions from direct contact with residents or their food if direct contact could transmit the disease.

(4) The facility shall require employees to perform hand hygiene after each direct resident contact for which hand hygiene is indicated by accepted professional practice.

(5) The facility shall handle, store, process, and transport linens so as to prevent the spread of infection.

.21-1 Employee Health Program.

A. The facility's infection control program shall monitor the relevant health status of all employees, as it relates to infection control. The following guidelines shall aid the facility in implementing its employee health program:

(1) Guideline for Infection Control in Health Care Personnel;

(2) Immunization of Health-Care Workers: Recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC); and

(3) COMAR 09.12.31.

B. Tuberculosis Control.

(1) The infection control program shall include a risk assessment program, including monitoring for tuberculosis infection for employees that is in accordance with the following guidelines:

(a) Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Facilities; and

(b) Guideline for Infection Control in Health Care Personnel.

(2) The facility shall ensure that all employees who may provide services that require direct access to residents may not provide such services without documented evidence that the employee is free from tuberculosis in a communicable form.

(3) The facility shall monitor the purified protein derivative (PPD) status of employees at any time that symptoms suggestive of tuberculosis develop, and periodically, consistent with the tuberculosis control plan. All employees shall be assessed for risk of tuberculosis following guidelines referenced in §B of this regulation.

(4) The facility shall maintain written documentation of the following:

(a) Results of tuberculin skin tests, recorded in millimeters of induration with dates of administration, dates of reading, results of test, and the manufacturer and lot number of the purified protein derivative (PPD) solution used;

(b) Results of chest x-rays required in this regulation; and

(c) Documentation of any tuberculin skin tests, chest x-ray, chemotherapy, and chemoprophylaxis, which are the basis for the certification that the individual is free from tuberculosis in a communicable form.

(5) The facility shall screen all new employees for immunity to common childhood infections such as mumps, rubella, measles, and chicken pox (varicella), through the use of pre-employment questionnaires and, if appropriate, serologic testing for presence of antibodies of these diseases, to prevent adult exposure of new employees to residents with communicable forms of such disease organisms.

(6) The facility shall request that all new employees receive immunization for Hepatitis B. The employee may refuse to be immunized if medically contraindicated, against the employee's religious beliefs, or after being fully informed of the health risks of not being immunized. If the employee refuses to be immunized, the facility shall document the refusal and the reason for the refusal.

(7) The facility shall request that each employee receive immunization from influenza virus in accordance with Health-General Article, §18-404, Annotated Code of Maryland. The facility shall make information available to all employees concerning other conditions in which pneumococcal vaccine may be of benefit for certain other underlying medical conditions. The facility shall document refusals and shall conduct surveillance of nonimmune employees during the recognized influenza season.

(8) The facility shall inquire about a history of varicella for each new employee. If the employee's history is unclear, then the facility shall request a serology for varicella. If the serology for varicella is nonreactive, the facility shall request that the employee receive immunization for varicella. If the employee refuses to be immunized, the facility shall document the refusal and the reason for the refusal.

.21-2 Resident Health Program.

A. The facility's infection control program shall include monitoring of the health status of all residents to determine if the residents are free from tuberculosis in a communicable form.

B. Tuberculosis Assessment.

(1) The facility shall assess residents for tuberculosis according to the following guidelines:

- (a) Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Facilities; and
- (b) Guideline for Infection Control in Health Care Personnel.

(2) All residents shall receive a tuberculin skin test within 10 days of initial admission unless the resident has had a documented negative skin test within the previous month, a previous positive test, history of preventive therapy, or treatment of tuberculosis.

(3) The tuberculin skin test for new admissions may be a two-step skin test that is performed by the facility according to the established infection control policy of the facility. Approved employees shall read the skin test and manage the results of the skin test in accordance with Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Facilities.

(4) The facility shall continue to monitor residents for signs and symptoms of tuberculosis by performing a yearly symptom review. When a resident has signs and symptoms of tuberculosis, a physician shall within 48 hours:

- (a) Evaluate the resident for tuberculosis in a communicable form;
- (b) Notify the health officer within 24 hours if the physician suspects tuberculosis; and
- (c) Coordinate management of the resident and the resident's contacts with the health officer.

(5) The facility shall assess and manage a resident with a history of previous positive tuberculin skin test, previous history of active tuberculosis, or positive skin test conversion in accordance with Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Facilities.

.21-3 Volunteer Health Program.

A. The facility shall urge that volunteers, defined as individuals who spend an average of 8 hours per week or more in the institution patient care areas and who receive no pay or benefits, accept annual influenza vaccination and tuberculin testing as considered necessary by the facility. The facility shall give appropriate health care information to such volunteers to provide maximum protection to residents.

B. The facility shall maintain documentation of the discussion between the facility and the volunteer concerning influenza vaccine and tuberculin testing.

.21-4 Infection Control—Standard Precautions.

A. Standard Precautions. All employees shall routinely use appropriate barrier precautions to prevent skin and mucous membrane exposure when contact with blood or the body fluids of any resident is anticipated as outlined in:

(1) Guideline for Isolation Precautions in Hospitals; and

(2) COMAR 09.12.31.

B. The infection control program shall include the handling of medical waste as defined in COMAR 10.06.06.

.22 Reports and Action Required in Unusual Circumstances.

A. Serious Emotional Disturbances. A facility may not accept or keep patients who destroy property or are dangerous to themselves or others, or who have acute symptoms of mental illness.

B. Action to Be Taken if a Patient Becomes Actively Disturbed. The following action shall be taken:

(1) If a patient becomes actively disturbed, the personal physician shall be notified immediately.

(2) A restraint may be used only if all of the following conditions are met:

(a) Failure to use a restraint or restraints is likely to endanger the health or safety of the patient or others;

(b) There is a written physician's order for the use of the restraint or restraints, which shall comply with the following requirements:

(i) The physician's written order for the restraint or restraints shall be for a specified maximum period of time, not to exceed 24 hours.

(ii) The necessity for the use of the restraint or restraints shall be documented, and

(iii) The frequency of patient observations by licensed personnel on not less than an hourly basis during the period of time that the restraint or restraints or the effects of the restraint or restraints are present shall be indicated;

(c) Appropriate documentation by licensed personnel shall be recorded in the clinical record;

(d) The facility may not re-impose a restraint or restraints except upon the written order of a physician who has personally observed the patient since the previous restraint or restraints order was imposed.

(3) A restraint or restraints may not be ordered PRN.

(4) If a physician is not immediately available, a registered nurse may authorize the use of a physical restraint or restraints for a period not to exceed 4 hours in any 30-day period. Licensed personnel shall observe the patient hourly. The patient shall be seen by a physician if the restraint or restraints are to be applied for more than the initial 4-hour period.

C. Locked Doors Prohibited. Patients may not be kept behind locked doors, that is, doors which patients cannot open. If the patient becomes too difficult to manage, the patient shall be transferred to a suitable facility selected by the attending physician. If the physician so orders, patients who have a tendency to wander may be confined to their rooms by screen doors or folding gates.

Agency Note: Supervision should be adequate to prevent patients from intruding into the rooms of other patients.

D. Unusual Occurrences. Any occurrence such as the occurrence of suspected mental disturbance, communicable disease, or symptomatic condition of importance to public health, poisoning, or other serious occurrence which threatens the welfare, safety, or health of any patient shall be reported immediately to the local health department. The administrator of the facility shall be responsible for seeing that appropriate procedures and reporting are carried out. An occurrence of a communicable or suspected communicable disease shall be reported and acted upon in accordance with medical asepsis as described in COMAR 10.06.01 Communicable Diseases and COMAR 10.15.03 Food Service Facilities.

Agency Note: Utilization Review. A utilization review plan should be developed with the advice of the professional personnel responsible for the establishment and enforcement of patient care policies. It is suggested that there be established a multi-discipline audit team to participate in an ongoing system of internal patient care audit.

.23 Transfer Agreement.

A. Written Agreement. A written agreement with at least one acute hospital shall be effected which shall provide for the following actions:

- (1) Planning to ensure that all services required for the continuity of patient care will be made available promptly;
- (2) Advance discussion with the patient regarding the reason for the transfer and any available alternatives;
- (3) Notification to the next of kin or responsible person regarding the anticipated transfer;
- (4) Interchange of medical and other information necessary in the care and treatment of patients transferred between the facilities;
- (5) Timely admission to the hospital when the attending physician determines acute hospital care is medically appropriate;
- (6) Safe transportation and care of the patient during transfer;
- (7) Security and accountability for the patient's personal effects;
- (8) Prompt readmission to the comprehensive care facility or the extended care facility at the end of the hospital stay (when program fiscal controls permit);
- (9) Annual review of execution of transfer arrangements (by utilization review committee or other designated group) to assure that each party is fulfilling the needs of both the patients and the providers (the hospital and the comprehensive care facility or the extended care facility);
- (10) If needs are not being met, it is the responsibility of the administrator of the comprehensive care facility or the extended care facility to act on recommendations of the reviewing group and to effect compliance;
- (11) Before licensure, the comprehensive care facility or the extended care facility shall submit to the Department a copy of the written agreement, signed by persons authorized to execute the agreement on behalf of the facilities;
- (12) Each facility shall maintain a signed copy of the agreement.

B. Facilities Under Common Control. If two facilities are under common control, a written agreement is not required; policies and procedures of both facilities shall provide assurance that § A(1)--(12) will be the practice of the facilities.

C. Exception for Comprehensive Care Facility. If a comprehensive care facility is unable to effect a transfer agreement with a hospital in the community and can document its attempts to secure an agreement, the facility shall be considered to have such an agreement in effect.

Agency Note: It is recommended that the comprehensive care facility arrange for a similar transfer agreement with an extended care facility.

.24 Emergency and Disaster Plan.

A. Emergency and Disaster Plan.

(1) The licensee shall develop an emergency and disaster plan that includes procedures that shall be followed before, during, and after an emergency or disaster, including:

(a) Evacuation, transportation, or shelter in place of residents;

(b) Notification of families and staff regarding the action that will be taken concerning the safety and well-being of the residents;

(c) Staff coverage, organization, and assignment of responsibilities for ongoing shelter in place or evacuation, including identification of staff members available to report to work or remain for extended periods; and

(d) The continuity of services, including:

(i) Operations, planning, and financial and logistical arrangements;

(ii) Procuring essential goods, equipment, and services to sustain operations for at least 72 hours;

(iii) Relocation to alternate facilities or other locations; and

(iv) Reasonable efforts to continue care.

(2) The licensee shall have a tracking system to locate and identify residents in the event of displacement due to an emergency or disaster that includes at a minimum the:

(a) Resident's name;

(b) Time that the resident was sent to the initial alternative facility or location; and

(c) Name of the initial alternative facility or location where the resident was sent.

(3) When the nursing facility relocates residents, the facility shall send a brief medical fact sheet with each resident that includes at a minimum the resident's:

(a) Name;

(b) Medical condition or diagnosis;

(c) Medications;

(d) Allergies;

(e) Special diets or dietary restrictions; and

(f) Family or legal representative contact information.

(4) The brief medical fact sheet for each resident described in §A(3) of this regulation shall be:

(a) Updated upon the occurrence of any change of information on the medical fact sheet;

(b) Reviewed at least monthly; and

(c) Maintained in a central location readily accessible and available to accompany residents in case of an emergency evacuation.

(5) The licensee shall review the emergency and disaster plan at least annually and update the plan as necessary.

(6) The licensee shall:

(a) Identify a facility, facilities, alternate location, or alternate locations that have agreed to house the licensee's residents during an emergency evacuation; and

(b) Document an agreement with each facility or location.

(7) The licensee shall:

(a) Identify a source or sources of transportation that have agreed to safely transport residents during an emergency evacuation; and

(b) Document an agreement with each transportation source.

(8) Upon request, a licensee shall provide a copy of the facility's emergency and disaster plan to the local emergency management organization for the purposes of coordinating local emergency planning. The licensee shall provide the emergency and disaster plan in a format that is mutually agreeable to the local emergency management organization.

(9) The licensee shall identify an emergency and disaster planning liaison for the facility and shall provide the liaison's contact information to the local emergency management organization.

(10) The licensee shall prepare an executive summary of its evacuation procedures to provide to a resident, family member, or legal representative upon request. The summary shall, at a minimum:

(a) List means of potential transportation to be used in the event of evacuation;

(b) List potential alternative facilities or locations to be used in the event of evacuation;

(c) Describe means of communication with family members and legal representatives;

(d) Describe the role and responsibilities of the resident, family member, or legal representative in the event of an emergency situation; and

(e) Notify families that the information provided may change depending upon the nature or scope of the emergency or disaster.

B. Evacuation Plans. The facility shall conspicuously post individual floor plans with designated evacuation routes on each floor.

C. Orientation and Drills.

(1) The licensee shall:

(a) Orient staff to the emergency and disaster plan and to their individual responsibilities within 24 hours of the commencement of job duties; and

(b) Document completion of the orientation in the staff member's personnel file through the signature of the employee.

(2) Fire Drills.

(a) The licensee shall conduct fire drills at least quarterly on all shifts.

(b) The licensee shall:

(i) Document completion of each drill;

(ii) Have all staff who participated in the drill sign the document; and

(iii) Maintain the documentation on file for a minimum of 2 years.

(3) Semiannual Emergency and Disaster Drill.

(a) The licensee shall conduct a semiannual emergency and disaster drill on all shifts during which the facility practices evacuating residents or sheltering in place so that each is practiced at least one time a year.

(b) The drills may be conducted via a table-top exercise if the licensee can demonstrate that moving residents will be harmful to the residents.

(c) Documentation. The licensee shall:

(i) Document completion of each drill or training session;

(ii) Have all staff who participated in the drill or training sign the document;

(iii) Document any opportunities for improvement as identified as a result of the drill; and

(iv) Keep the documentation on file for a minimum of 2 years.

(4) The licensee shall cooperate with the local emergency management agency in emergency planning, training, and drills and in the event of an actual emergency.

.25 Location and Communication.

The site of the facility shall be approved by the Department. It shall be located in an area convenient to professional personnel and other employees. The environment shall be free from excessive noise and air pollution. In new facilities sound transmission limitations shall be in accordance with Standard No. E 90 of the American Society for Testing and Materials (ASTM), as revised from time to time. The facility shall be located on a well-drained site not subject to flooding. If it is served by private access roads, the facility shall maintain the roads in passable condition at all times. The following criteria shall control location of a facility proposed to be located near an airport:

A. Class I, Military Airports Handling Heavy Aircraft. Medical facilities may not be located beneath the approach/departure corridors. The corridor shall be defined as 2 miles wide and 5 miles long beginning at the end of the runway. Medical facilities may not be located beneath the airport traffic pattern, the pattern being defined as a 1 mile wide track centered on the nominal traffic pattern.

B. Class II, Commercial Airports Handling Heavy Commercial Aircraft. Medical facilities may not be located beneath the approach/departure corridor. The corridor shall be defined as 2 miles wide and 5 miles long beginning at the end of the runway.

C. Class III, Military and Commercial Airports Handling Light Aircraft and General Aviation. Medical facilities may not be located beneath the approach/departure corridor or traffic pattern. The corridor shall be 1 mile wide and 3 miles long beginning at the end of the runway, the traffic pattern restriction being defined as a 1 mile wide track centered on the nominal pattern.

D. Applicant's Responsibility to Supply Traffic Pattern Data. It shall be the responsibility of the applicant to furnish all data on corridors and patterns as described above for the purpose of site approval. This data shall be submitted at the same time the facility submits information to Comprehensive Health Planning. The Department's response to the facility shall be made within the same time frame required for Comprehensive Health Planning.

E. New Facilities. In new construction the noise level may not exceed 40dB(A).

F. Class IV, Heliports. No restrictions when used exclusively for health care purposes. Facilities located near heliports used for purposes other than health care shall meet sound transmission limitations in accordance with Standard No. E 90 of the American Society for Testing and Materials (ASTM), as revised from time to time.

G. All existing facilities and those facilities approved by the Department before the adoption of these regulations shall be exempt from the location requirements of these regulations.

.26 Physical Plant General Requirements.

Unless otherwise indicated, all general requirements apply to both new construction and existing facilities.

A. Construction—New Facilities. Facilities shall be constructed, equipped, and maintained to protect the health and safety of patients, personnel, and the public.

B. Construction of New Facilities. New facilities shall be defined as facilities for which plans have been submitted and approved subsequent to the adoption of these regulations and shall meet the following criteria:

(1) Building shall be a completely detached structure.

(2) A facility desiring to provide services other than those licensed shall obtain prior approval from the Department. The facility also shall obtain prior approval from the Department for any part of the premises to be used for tenant occupancy or for unrelated business purposes. Any such usage shall require the facility to follow guidelines to be established by the Department.

(3) All facilities shall be constructed in accordance with the provisions of the NFPA 101-Life Safety Code, as promulgated by the State Fire Prevention Commission, as are applicable to nursing homes.

(4) Facilities constructed after July 1, 1977 which will house 50 or more occupants needing evacuation assistance (as enforced by the State Fire Marshal) shall be protected throughout the entire building by an automatic fire extinguishing system. (This requirement does not apply to Washington County. See Washington County local building code.)

(5) Basements—New Facility Construction. On new construction of one-story or multi-story facilities scheduled to have basements, the following requirements shall be met: In basements of fire resistive buildings where special fire hazards are identified by fire authorities' review of plans, automatic sprinkler protection shall be required as indicated by the fire authority.

(6) The facility shall be in compliance with all applicable State and local governing laws, regulations, standards, ordinances, and codes.

(7) The facility shall be constructed to comply with ANSI A117.1-1961, (Reaffirmed 1971) American National Standard Institute Specifications for making buildings accessible to, and usable by, the physically handicapped.

(8) Securely anchored handrails shall be provided on each side of all corridors in patient areas and shall be 36 inches high, measured from the floor to the top of the handrail.

Agency Note: In existing structures, the Department will entertain requests for waivers on items which will not endanger the health and safety of persons using the facility; patients and visitors; and for those items, if corrected, which will result in an unreasonable hardship upon the facility, that is, cause substantial financial burden.

C. Conversion of an Existing Structure. When an owner plans to convert an existing structure which has not been licensed as a nursing or care home to a comprehensive care facility or an extended care facility the owner shall be required to meet all conditions set forth in "New Facility Construction Requirements."

Agency Note: This would, for example, relate to hotels, apartment houses, private homes, and other types of institutions.

D. Elevators—New Construction. Elevators shall meet the requirements for elevators in long-term care facilities as set forth in the "Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities, DHEW Publication No. (HRA) 76-4000, or as amended".

E. Elevators—Existing Facilities. In existing facilities all local codes and standards for safety and maintenance of institutional elevators shall be met.

F. Emergency Electrical Power—New Construction and Existing Facilities. Emergency electrical power shall be provided as detailed in this section:

(1) Emergency power for the purpose of egress lighting and protection shall be as required by the Maryland State Fire ...state.md.us/.../10.07.02.26.htm

Prevention Code and Life Safety Code 101 as adopted by the State Fire Marshal's Office.

(2) Other emergency lighting shall be as follows:

- (a) Nursing station;
- (b) Drug distribution station or unit dose storage;
- (c) A lighted area for emergency telephone use;
- (d) Boiler or mechanical room;
- (e) Kitchen;
- (f) Generator set location and switch gear location;
- (g) Elevator, if operable on emergency power;
- (h) Areas where life support equipment is used;
- (i) If applicable, lighting for common area of refuge;
- (j) If applicable, lighting in toilet rooms of common area of refuge;

(3) Emergency power shall be provided for the following:

- (a) Nurses' call system.
- (b) Duplex receptacles installed 50 feet apart in all corridors in patient areas, or appropriately located duplex receptacles in the common area of refuge, if applicable.
- (c) Telephone service. At least one telephone shall be available for incoming and outgoing calls.
- (d) Fire pump.
- (e) Sewerage pump and sump pump.
- (f) Elevator, if required for evacuation. If the facility's evacuation plan requires the use of the elevator or elevators, emergency power shall be provided in accordance with ANSI standards as enforced by the Division of Labor and Industry, Elevator Safety Section. If there is more than one elevator, there shall be switchover facilities to operate one elevator at a time.
- (g) Necessary heating equipment to maintain a minimum temperature of 70°F (24°C) in all common areas of refuge, if applicable.
- (h) Life support equipment.
- (i) Nonflammable medical gas systems.

(4) Common Area or Areas of Refuge. If all patient rooms and toilet rooms are not tied into the emergency generator to provide heat in an emergency situation, the facility shall provide common area or areas of refuge for all patients as described below:

- (a) An area of not less than 30 square feet per bed (2.79 square meters), exclusive of corridors, shall be designated by the facility as the common area or areas of refuge.
- (b) The 30 square feet (2.79 square meters) per bed shall include a minimum of 5 percent of the patient bedrooms. A minimum temperature of 70°F (24°C) shall be maintained in this area.
- (c) Heated toilet rooms adjacent to the common areas of refuge shall be provided. These toilet rooms are not reflected in the 30 square feet (2.79 square meters) per bed.
- (d) The facility shall provide to the Department for approval a written plan which defines the specified area or areas of

refuge, and outlines paths of egress from the common areas of refuge, the provision for light, heat, food service, and the washing and toileting of patients.

(5) Emergency Power Source. The emergency power source shall be a generating set and prime mover located on the premises with automatic transfer. The following are required as part of the emergency power system:

(a) In the event of failure of the normal electrical service, the emergency power shall be activated immediately.

(b) The emergency generator set shall come to full speed and load acceptance within 10 seconds.

(c) The emergency generator shall have a capability of 48 hours of operation from fuel stored onsite.

(d) The emergency power system shall be tested once a month. The system shall be exercised for a minimum of 30 minutes under normal emergency facility connected load and recorded in a permanent log book maintained for that purpose.

(6) Applicability of Emergency Power Requirements.

(a) Within 12 months of the effective date of these requirements, existing facilities of 150 beds or more shall complete the installation and acceptance of a working system as required in this section.

(b) Within 18 months of the effective date of these requirements, existing facilities of 50 to 149 beds shall complete the installation and acceptance of a working system.

(c) Existing facilities of 49 beds or less shall have the option to:

(i) Install an acceptable system within 18 months of the effective date of these requirements; or

(ii) Provide a written evacuation/relocation plan for patients which shall be approved by the Department. There shall be a signed agreement between the nursing facility and the facility which agrees to accept the patients for the duration of the emergency. The agreement shall specify that there is sufficient emergency electrical power coverage to provide the care and services required by the patients admitted. A facility which opts to evacuate patients during an emergency shall be in compliance with requirements for emergency power for the purpose of egress as required by the Maryland State Fire Prevention Code and the Life Safety Code 101, as adopted by the State Fire Marshal's Office.

G.—H. (Repealed)

I. Lighting—New Construction and Existing Facilities. Each patient's room shall be lighted by outside windows and also shall have artificial light adequate for reading and other uses as required. All entrances, hallways, stairways, inclines, ramps, basements, attics, storerooms, kitchens, laundries, and service units shall have sufficient artificial lighting to prevent accidents and promote efficiency of service.

J. Minimally Maintained Lighting Levels—New Construction and Existing Facilities. Lighting shall be adequate for activities conducted in given areas:

Area	Minimum Lighting
(1) Administrative areas	30 foot candles
(2) Dining areas	30 foot candles
(3) Recreation areas	100 foot candles
(4) Patient's room	10 foot candles
(5) Patient's reading lamps	30 foot candles
(6) Nurses' station	20 foot candles
(7) Medicine storage and preparation area	100 foot candles
(8) Stairways	20 foot candles
(9) Corridors	20 foot candles

K. Night Lights-New Construction and Existing Facilities. There shall be sufficient lighting at night in selected areas of the

facility (hallways, stairs and designated toilets) for the safety of the patient who must get up during the night. There also shall be one night light in each bedroom for patients. In new construction the night light shall be switched at the patient room door.

L. Heating System. All facilities shall be equipped with a properly maintained and operative central heating system capable of maintaining 75°F throughout the patients' section of the building with the outside temperature defined by ASHRAE, American Society of Heating, Refrigerating and Air Conditioning Engineers, winter median of extreme temperature.

M. Approved Heating System. The heating system shall be in compliance with NFPA Code and all State and local codes.

N. Humidity. The humidity shall be controlled according to ASHRAE recommendations.

O. Auxiliary Heat—New Construction and Existing Facilities. Appropriate provisions shall be made for emergency auxiliary heat by means of alternate sources of electric power, alternate fuels, or standby equipment.

P. Space Heaters. Space heaters and portable heaters may not be used.

Q. Ventilation—New and Existing Facilities. Existing facilities shall provide for adequate ventilation through windows or mechanical means or or a combination of both. New facilities shall meet the following requirements:

(1) Temperatures. A minimum design temperature of 75°F (24°C) at winter design conditions shall be provided for all occupied areas.

(2) Ventilation System Details. All air-supply and air-exhaust systems shall be mechanically operated. All fans serving exhaust systems shall be located at the discharge end of the system. The ventilation rates shown in Table 1, §Q, below, shall be considered as a minimum acceptable rates and may not be construed as precluding the use of higher ventilation rates.

(a) Outdoor air intakes shall be located as far as practical but not less than 25 feet (7.62m) from exhaust outlets of ventilating systems, combustion equipment stacks, medical-surgical vacuum systems, plumbing vent 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 6 feet (1.83m) above ground level, or if installed above the roof, 3 feet (91 cm) above roof level.

(b) The ventilation systems shall be designed and balanced to provide the pressure relationship as shown in Table 1.

(c) The bottoms of ventilation openings shall be not less than 3 inches (7.6 cm) above the floor of any room.

(d) Corridors may not be used to supply air to or exhaust air from any room, except that air from corridors may be used to ventilate bathrooms, toilet rooms, janitors' closets, and small electrical or telephone closets opening directly on corridors.

(e) All central ventilation or air conditioning systems shall be equipped with filters having efficiencies no less than those specified in Table 2. The filter bed shall be located upstream of the air conditioning equipment, unless a prefilter is employed. In this case, the prefilter shall be upstream of the equipment and the main filter bed may be located further downstream.

(f) All filter or filters efficiencies shall be average atmospheric dust spot efficiencies tested in accordance with ASHRAE Standard 52-68. Filter frames shall be durable and carefully dimensioned and shall provide an airtight fit with the enclosing duct work. All joints between filter segments and the enclosing duct work shall be gasketed or sealed to provide a positive seal against air leakage. A manometer shall be installed across each filter bed serving central air systems.

(g) Air handling duct systems shall meet the requirements of NFPA Standard 90A, 1976 Edition.

(h) Fire and smoke dampers shall be constructed, located, and installed in accordance with the requirements of NFPA Standard 90A, 1976 Edition. Return, supply, and exhaust ducts which pass through a required smoke barrier, through which smoke can be transferred to another zone shall be provided with smoke dampers at the barrier, controlled to close automatically to prevent flow of air-laden smoke in either direction. Smoke dampers shall be equipped with automatic remote control reset devices except that manual reopening will be permitted if smoke dampers are conveniently located. All air ducts which pass through a required smoke barrier shall be provided with smoke damper at the barrier, actuated by smoke or products of combustion (other than heat) detectors. Smoke dampers shall actuate by smoke detectors located in the ducts at the smoke barrier, or by the smoke detectors used to close smoke barrier doors. All devices shall be interlocked with the fire alarm system. Reference should be made to the Life Safety Code, Chapter 10, NFPA 101.

Table 1

Pressure Relationships and Ventilation of Certain Areas of Long-Term Care Facilities Other Than Chronic Disease Hospitals					
Area Designation	Pressure Relationship To Adjacent Areas	Minimum Air Changes of Outdoor Air Per Hour Supplied To Room	Minimum Total Air Changes Per Hour Supplied To Room	All Air Exhausted Directly To Outdoors	Recirculated Within Room Units
Patient Room	E	2	2	Optional	Optional
Patient Area Corridor	E	2	4	Optional	Optional
Examination and Treatment Room	E	2	6	Optional	Optional
Physical Therapy	N	2	6	Optional	Optional
Occupational Therapy	N	2	6	Optional	Optional
Soiled Workroom or Soiled Holding	N	2	10	Yes	No
Clean Workroom or Clean Holding	P	2	4	Optional	Optional
Toilet Room	N	Optional	10	Yes	No
Bathroom	N	Optional	10	Yes	No
Janitors' Closet(s)	N	Optional	10	Yes	No
Sterilizer Equipment Room	N	Optional	10	Yes	No
Linen and Trash Chute Room	N	Optional	10	Yes	No
Food Preparation Center	E	2	10	Yes	No
Warewashing Room	N	Optional	10	Yes	No
Dietary Day Storage	E	Optional	10	Yes	No
Laundry, General	E	2	10	Yes	No
Soiled Linen Sorting and Storage	N	Optional	10	Yes	No
Clean Linen Storage	P	2	2	Optional	Optional

P = Positive N = Negative E = Equal

Table 2

Filter Efficiencies for Central Ventilation and Air Conditioning Systems in Long-Term Care Facilities Other Than Chronic Disease Hospitals		
Area Designation	Minimum Number of Filter Beds	Filter Efficiencies (Percent) Main Filter Bed
Patient Care, Treatment, Diagnostic, and Related Areas	1	80*
Food Preparation Areas and Laundries	1	80
Administrative, Bulk Storage and Soiled Holding Areas	1	25

*May be reduced to 35 percent for all-outdoor air systems.

(i) In new construction and existing facilities, exhaust hoods in food preparation centers shall have an air movement exhaust rate of not less than 50 feet per minute in the direction of the exhaust as measured at the front edge of the cooking surface. All hoods over cooking surfaces shall be in compliance with NFPA, #96, 1973 Edition, Standard for the Installation of Equipment for the Removal of Smoke and Grease-laden Vapors from Commercial Cooking Equipment.

(j) New Construction and Existing Facilities. Boiler rooms shall be provided with sufficient outdoor air to maintain combustion rates of equipment and to limit temperatures in working stations to 97°F (36°C) effective temperature as defined by ASHRAE Handbook of Fundamentals.

R. Air Conditioning. All new facilities shall be equipped with a properly maintained air conditioning system capable of maintaining 75° throughout the patients' section of the building. The system shall be in compliance with ASHRAE and NFPA Code and all State and local codes.

S. Screens, New Construction and Existing Facilities.

(1) Health care facilities shall be protected effectively to prevent the entrance and harborage of rodents and insects. Screening, rat-proofing devices, or other approved deterrents shall be installed and effectively maintained.

(2) All openings to the outside air shall be protected effectively against the entrance of insects by closed doors, closed windows, or other means.

(3) Openings for which the intended use is to provide for the normal flow of ingress and egress of traffic shall be protected by self-closing doors.

(4) Doors and windows normally operated in the open position to provide ventilation shall be screened with wire screen or its equal, not less than 16 meshes per linear inch.

(5) All screened doors shall be equipped with self-closing devices and when closed shall fit tightly enough to prevent entrance of rodents and insects.

(6) Window screens shall fit closely enough to keep out rodents and insects and shall be adjusted easily.

(7) Screened doors and windows shall be installed and maintained in accordance with applicable fire and safety codes and COMAR 10.15.03 Food Service Facilities. Maintenance and installation may not be in conflict with other applicable laws, regulations, codes, or ordinances.

T. Garbage Disposal. Garbage shall be stored in water-tight containers with tight-fitting covers, and shall be emptied at frequent intervals. Containers shall be thoroughly scoured and aired before using again.

U. Storage Space-Garbage. Storage space shall be provided for garbage and trash awaiting pickup.

V. Burning. If burning is the method used for disposal when no satisfactory garbage collection service is available for the purpose, an approved incinerator shall be used. The method of incinerator installation shall be approved by the local environmental representative of the county health department.

W. Medical Wastes. Disposal of medical wastes shall be accomplished in accordance with regulations promulgated by the Department or other State or federal agencies.

X. Plumbing. All plumbing shall be installed in conformance with existing building and sanitary regulations except that, in existing facilities, a nonconforming installation which is not an immediate hazard shall be corrected upon replacement.

Y. Sewage. The facility shall be serviced by a public sewage disposal system if available.

Z. Private Sewage Disposal Approval. If no approved public sewerage system is available, a private sewage disposal may be accepted, if approved by the Department. Private systems shall comply with COMAR 26.04.02.

AA. Water Supply. Facilities shall be served by water from a safe public water supply, if available, as determined by the Department.

BB. Approval of Private Water Supply. If a safe public water supply is not available, a private water supply may be used if it is approved by the Department.

CC. Emergency Procedures. Emergency procedures shall be established and documented which enable the facility to provide water in all essential areas in the event of the loss of the normal water supply.

DD. Adequacy of Pressure. The water supply shall be adequate in quantity and delivered under sufficient pressure to satisfactorily serve fixtures in the facility. A minimum pressure of 15 psi is required at top floor fixtures during demand period.

EE. Temperature. The water heating equipment shall supply adequate amounts of water according to the following temperature guidelines for:

- (1) Washing, bathing, and other personal use, not more than 120°F or less than 100°F;
- (2) Food preparation use, in conformance with COMAR 10.15.03; and
- (3) Laundry use, in conformance with the water supply standards of the American Laundry Institute.

FF. Smoking. Each patient who must be confined to a bed for the greater part of the day shall be asked about his sensitivity or objection to smoking. Insofar as possible, non-smokers shall be housed with other non-smokers. Smoking areas shall be designated and ash trays of non-combustible material and safe design shall be provided. Patients may not smoke in bed except when confined to bed and supervised by a competent employee during the entire period of smoking.

Agency Note: In developing the facility's policy regarding smoking, refer to Health-General Article, §24-205, Annotated Code of Maryland.

.27 Nursing Care Unit.

A. Size. Nursing care units may not exceed 60 beds. The Department may specify the numbers and types of personnel for each unit which exceeds 40 beds.

B. Service Areas Required in New Construction or for New Facilities.

(1) Nurses' Station. The nurses' station shall be centrally located in relation to beds served and shall provide easy view of corridors outside of rooms. The Department may specify the location and size of a nurses' station which serves a nursing care unit exceeding 40 beds. A nursing care unit also shall include:

(a) A toilet, within the care unit, for the use of personnel, a handwashing sink equipped with 4 inch wrist blades, goose-neck spout, and separate soap dispensers and towel dispensers.

(b) Medicine storage cabinet with locks. Schedule II drugs shall be kept in separately locked, securely fixed boxes or drawers in a cabinet, under two locks, keyed differently; medicine storage and preparation area with illumination of 100 footcandles at the work counter; preparation area shall include a small sink set into the counter or with drain boards; biological refrigerator. Spaces housing medicine storage cabinet, medicine preparation area, and biological refrigerator shall be under the direct visual control of the nursing or pharmacy staff.

(c) Nurses' call system.

(d) Charting desk and supplies.

(e) Storage space for miscellaneous medical supplies which shall be protected from contamination.

(f) Sufficient space and equipment for medical records which enables personnel to function in an effective manner and to maintain records on all patients so they are easily accessible.

(2) Nurses' Station—Existing Facility. Each care unit shall have a nurses' station provided with a medicine storage cabinet and preparation counter or table having adequate lighting overhead. A handsink with hot and cold running water shall be convenient to the nurses' station.

(3) Because specific temperatures are often required for the safe storage of drugs, the storage facilities shall provide for the following conditions when prescribed:

(a) Cold—Any temperature not exceeding 8°C (46°F). A refrigerator is a cold place in which the temperature is maintained thermostatically between 2°C and 8°C (46° and 59°F). A freezer is a cold place in which the temperature is maintained thermostatically between -20°C and -10°C (-4° and -14°F).

(b) Cool—Any temperature between 8°C and 15°C (46° and 59°F). An article for which storage in a cool place is directed may, alternatively, be stored in a refrigerator, unless otherwise specified in the individual monograph.

(c) Room Temperature—The temperature prevailing in a working area. Controlled room temperature is a temperature maintained thermostatically between 15°C and 30°C (59° and 86°F).

(d) Warm—Any temperature between 30°C and 40°C (86° and 104°F).

(e) Excessive Heat—Any temperature above 40°C (104°F).

(f) Protection from Freezing. When, in addition to the risk of breakage of the container, freezing subjects a product to loss of strength or potency, or to destructive alteration of the dosage form, the container label bears an appropriate instruction to protect the product from freezing.

(g) Storage under Non-specific Conditions. When no specific storage directions or limitations are provided in the individual monograph, it is to be understood that the storage conditions include protection from moisture, freezing, and excessive heat.

(4) Space for Storage of Linen—New Construction and Existing Facilities. Capacity shall be provided for storage of at least two complete changes per bed. Clean linen shall be stored separately from non-clean items.

(5) Janitors' Closet—New Construction. Each nursing unit shall contain at least one janitors' closet containing a floor receptor or service sink and storage space for housekeeping equipment and supplies. The janitors' closet shall be equipped for handwashing.

(6) Utility Rooms—New Construction.

(a) There shall be separate clean and soiled utility rooms in each nursing unit, accessible to the patient area, no more than 120 feet to the most remote patient bedroom. There shall be a separate entrance into each room.

(b) The clean utility room shall contain:

(i) Wall and base cabinets with stain resistant counter top;

(ii) A small sink set into the counter, or with drainboards; sink shall be equipped with gooseneck spout and wrist blades;

(iii) Adequate storage and work counter space for storage and assembly of supplies for nursing procedures;

(iv) Provision for storing and transporting clean linen in covered container. Clean linen may also be stored in closed linen carts or rooms exclusively provided for this purpose, if approved by the Department.

(c) The soiled utility room shall contain:

(i) Work counter with sink, gooseneck faucet, and wrist blades;

(ii) A separate wall-hung hand sink for handwashing, equipped with wrist blades and soap and towel dispensers;

(iii) Space for waste receptacles and soiled linen receptacles; provision for storing and transporting soiled linen in covered leakproof containers;

(iv) Equipment, approved by the Department, to clean and sanitize bedpans, urinals, and basins.

(7) Utility Rooms—Existing Facility. In existing facilities service areas shall be provided for patient care items which are acceptable to the Department.

C. Call System—New Construction. A call system shall be installed and maintained in operating order in all nursing units. Call systems shall be maintained in a manner that will provide visible and audible signal communication between nursing personnel and patients. The minimum requirements are:

(1) A call station or stations providing detachable extension cords to each patient's bed in the patients' rooms. These extension cords shall be readily accessible to patients at all times.

(2) A visible signal in the corridor above the corridor door of each patient's bedroom, visible from all parts of the corridor.

(3) An audible signal and a nurses' call enunciator indicating the room from which the call originates or an alternate system approved in writing by the Department, shall be located at the nurses' station. The sounding of the audible signal shall be continuous or intermittent until answered. The audible signal may not be turned off at the nursing station.

(4) A call system shall be provided in each patient's toilet room, bathroom, and shower stall in locations easily accessible to the patients. The call system shall enable patients in the rehabilitation area to summon rehabilitation staff.

(5) The nurses' call system shall be so designed as to require resetting at the station where the call originates.

D. Call System—Existing Facilities. Existing facilities (those facilities licensed at the time this regulation becomes effective) shall provide some method/means of a patient summoning aid that shall include as minimum a combined visual and audible signal that is audible at the nurses' station and simultaneously activates a light located in the hall, outside of and adjacent to the patient's room. The activating device for those signals shall be located in each patient's room and each and every bathing compartment and toilet room or compartment used by patients. Exceptions may be made in part at the discretion of the

Department for an individual facility only when the facility can demonstrate compliance with the intent of this section by showing an effective patient call system to provide quality patient care.

E. Drinking Fountains. One public drinking fountain shall be provided one each floor, usable from a wheelchair.

.28 Resident Bedroom and Toilet Facilities.

A. Unless otherwise noted, requirements are applicable to existing facilities as well as new facilities.

B. Bedroom Accommodations. The following requirements shall be met:

- (1) Each patient's room shall have direct access to an exit as specified by the Life Safety Code.
- (2) A room which opens into the kitchen may not be used as a patient bedroom.
- (3) A room may not be used as a patient bedroom which necessitates passing through a kitchen to reach any other area.
- (4) Patients may not occupy rooms extending below the ground level.
- (5) More than six persons may not occupy a multiple occupancy bedroom.
- (6) Care shall be exercised to prevent beds from being located near radiators, registers, or sources of draft.
- (7) In new construction, cubicle curtains and tracks shall be provided in multiple occupancy bedrooms between beds to insure privacy of patients when necessary.

Agency Note: In existing facilities, curtains or screens shall be acceptable.

(8) Adequate closet space shall be provided in, or convenient to, each bedroom to allow each patient to keep necessary items of clothing. Where closets are locked, a master key or duplicate key shall be available in the administrator's office. Adequate storage space shall be provided for patients' personal possessions, including the storage of seasonal clothing.

(9) Each facility shall maintain, at all times, the capability to physically isolate any patient who may contract a communicable disease from the remaining patient population. This shall include access to bathing and toilet facilities not used by the rest of the patient population.

(10) All occupants of any bedroom shall be of the same sex, except in the case of a two-bed room occupied only by husband and wife.

C. Floor and Window Space. The following requirements shall be met:

- (1) A distance of at least 3 feet shall be maintained between each bed. Each bed is to be placed so that all sides of the bed are at least 18 inches from walls or heating units.
- (2) The following allowance of floor space shall be considered a minimum:
 - (a) Single-bed room----100 square feet.
 - (b) Multiple-bed rooms----80 square feet (per bed).

Agency Note: Recommended for multi-bed rooms, 100 square feet per bed; single-bed rooms, 125 square feet per bed.

- (3) For any bedroom in a new facility, the following floor areas may not be included in the calculation of floor space:
 - (a) The floor area of toilet rooms and bathing facilities;
 - (b) The floor area of closets;
 - (c) The floor area occupied by wardrobes, bureaus, or lockers;
 - (d) The floor area occupied by, or directly under, any HVAC equipment, including any steam, water, or electrical supply or return lines which may run parallel to the floor, or interrupt the floor surface;

(e) The floor area occupied by any support columns, pipe chases, or other structure, whether free-standing or as an integral part of a wall; and

(f) The floor area described by the arc of any door, excluding closet doors, which opens into the room.

(4) For any bedroom in a new facility, the minimum horizontal dimension is to be 10 feet to facilitate the placement of beds as required in §C(1) of this regulation and to maintain a minimum clearance of 3 feet at the foot of the bed.

(5) In existing facilities, the usable floor area for rooms having sloping walls shall be calculated for bed occupancy only for that area having a ceiling height of 8 feet and 50 percent of the area having ceiling height of between 4 feet and 7 feet 6 inches provided that at least 50 percent of the total area has a ceiling height of 8 feet. The minimum horizontal dimension of any room shall be 9 feet.

(6) The window area may not be less than 10 square feet per bed, half of which is able to be opened. A window opening shall be at least 28 inches X 28 inches (to permit entry of firemen, removal of smoke, and emergency evacuation). In case of air-conditioning, the presence of portable air-conditioning units may not block window space. The installation of portable air-conditioning units shall be approved by fire authorities.

D. Furnishings. The following shall be provided;

(1) Each patient shall be provided with his own bed which shall be at least 36 inches wide, be substantially constructed and in good repair. Rollaway type beds, cots or folding beds may not be used.

(2) Each bed shall be provided with satisfactory type springs in good repair, and a clean comfortable mattress, standard in size for the bed.

(3) Each bed shall be provided with a clean, comfortable pillow. Extra pillows shall be available.

(4) Each patient shall be provided with the following furnishings which shall be convenient to the patient:

(a) Bedside stand with a drawer.

(b) Towel rack. A towel rack in an existing private bathroom satisfies this requirement.

(c) A comfortable chair.

(d) At least two dresser drawers in a chest of drawers.

(e) Enclosed space for hanging clothing.

(f) Wall mirror in each room (unless contraindicated by physician's order).

(g) Bedside lamp or other directional light source for patient reading or bedside care, or both.

(5) Windows shall be provided with shades or draperies adequate to control glare and maintain privacy.

(6) Each living room for patients' use shall be provided with a sufficient number of reading lamps, tables, and comfortable chairs or sofas.

(7) In new construction each patient's room shall be provided with a lavatory with both hot and cold running water unless private toilet or bathroom facilities are connected to the bedroom.

(8) There shall be at least one bathtub or shower, or bathing device (approved by the Department), in a separate room or compartment for each 12 beds. The compartment shall be large enough to accommodate wheelchair and attendant.

(9) There shall be at least one toilet room on each floor large enough to accommodate wheelchair and attendant, to permit toilet assistance or training.

Agency Note: If the toilet facilities described above are provided in private patient toilet rooms, a separate toilet room on every floor will not be required. An inter-connecting bathroom may not be considered a private bath.

(10) For each eight beds there shall be at least one toilet enclosed in a separate room or stall.

(11) There shall be one lavatory for every four beds.

(12) For handwashing purposes there shall be a towel dispenser and a supply of paper towels and soap dispenser adjacent to all lavatories.

(13) Bedpans, Urinals, and Basins-----New and Existing Facilities.

(a) Each floor of the facility shall be equipped with equipment, approved by the Department, to clean and sanitize bedpans, urinals, and basins.

(b) Common-use pans and urinals shall be cleaned and sanitized after each patient use (sanitization by heat, chemicals, gas, or other means approved by the Department).

(c) Disposable pans and urinals shall be cleaned and sanitized when needed or at least weekly; they shall be discarded when damaged or no longer in cleanable condition. Disposable pans, even though sanitized, may not be transferred from one patient to another.

(d) Pans and urinals used in isolation cases shall be sterilized by approved methods.

E. Body Holding Room-----New and Existing Facilities. In a new facility, if a body holding room is provided, it shall be located to facilitate quiet and unobtrusive ingress and egress of bodies, convenient to the elevator and with an isolated exit. If a body holding room is not provided, a holding area shall be designated which approximates the above conditions.

Agency Note: Existing facilities shall provide a method for holding which minimizes the psychological effect on other patients in the home.

.29 Equipment and Supplies for Bedside Care.

A. Needs of Patients. There shall be sufficient equipment to meet the needs of the type patients admitted. It shall be the responsibility of the administrator to obtain specific items required for individual cases where requested by the attending physician or supervisor of care services. The Department may require specific types of equipment based on the needs of the patients. All facilities shall establish and enforce a written preventive maintenance program to ensure that all essential mechanical, electrical, and patient care equipment is maintained in safe operating condition.

B. Use of Hot Water Bottles and Ice Caps. Covers shall be placed on hot water bottles and ice caps before they are placed in a bed or on a patient. The water temperatures in hot water bottles may not exceed 120°F. Heating pads may not be used instead of hot water bottles.

.30 Rehabilitation Facilities — Space and Equipment.

A. Space.

(1) There shall be adequate space for the reception, examination, and treatment of patients; storage of supplies and equipment including wheelchairs and stretchers; and office space for the personnel employed;

(2) Seventy-five square feet shall be allotted for treatment area per patient based on peak treatment schedules:

Agency Note: Recommended space: Storage—10 percent of area designated for exercise and rehabilitation; Office—one therapist, 110 square feet; two or more, 85 square feet per therapist.

(3) Space may be planned and arranged for shared use by physical therapy and occupational therapy staff and patients if scheduling permits.

B. Equipment.

(1) Equipment shall be of a type that will provide safe and effective patient care.

(2) All electrical equipment shall be calibrated according to manufacturers' directions and shall be periodically serviced as part of a preventive maintenance program. A sticker bearing the date of the most current inspection shall be affixed on each piece of equipment.

(3) All electrical equipment shall be periodically tested for proper grounding, current leakage, and calibration where appropriate.

(4) Operator's instruction booklet shall be available in a designated location at all times.

(5) All flammables shall be stored in compliance with NFPA 30, flammable and combustible liquids code.

(6) Due care shall be taken in using vaporous materials or pollutants.

C. Toilet Facilities in Rehabilitation Area. In new construction, facilities with rehabilitation areas shall provide a lavatory and toilet which meet ANSI standards for wheelchair patients. These facilities shall be readily accessible to the rehabilitation patients.

.31 Dayroom and Dining Area.

A. Resident Dining, Occupational Therapy, and Activities Program. There shall be provided one or more attractively furnished areas of adequate size for resident dining, occupational therapy, and social activities. Activities space of adequate size to meet the needs of the residents shall be located on each floor occupied by residents.

B. Dining Area. In all facilities, the dining area shall be large enough to accommodate all patients able to eat out of their rooms. There shall be an allowance of at least 12 square feet per ambulatory patient; this allowance shall be substantially increased proportionately to wheelchair cases. There shall be at least 12 square feet per bed for 50 percent of the total licensed beds.

C. Dayroom Area. Dayroom areas shall be provided, adequate for the patients capable of using them and convenient to patients' bedrooms.

D. Multi-purpose Room. If a multi-purpose room is used for dining, occupational therapy, and social activities, there shall be sufficient space to accommodate all activities without interference with each other. The total areas set aside for patients' dining and recreation areas shall be no less than 30 square feet per bed for the first 100 beds and 27 square feet per bed for all beds in excess of 100.

.32 Dietetic Service Area.

A. Food Service Department. The location of the food service are shall be approved by the Department. A facility which holds full licensure as of the adoption of these regulations shall be considered as having an appropriately located food service area. A catered or satellite system shall be covered by a contract approved by the Department.

B. Outside Service Entrance. A convenient outside service entrance shall be planned to facilitate receiving food supplies and the disposal of waste.

C. Restriction—Entry to Kitchen or Serving Pantry. A toilet room or sleeping room may not open directly into any kitchen or serving pantry.

D. Limitations on Use of Kitchen. The kitchen may not be used as a passageway. It shall be used for no other purpose than activities connected with food service.

E. Janitor's Closet or Service Area.

(1) New Construction. A janitor's closet or service alcove for exclusive use of food service areas shall be provided in, or adjacent to, the dietetic service department. It shall be equipped with a utility sink, storage shelves, and a rack for hanging brooms and mops.

(2) Existing Facility. A utility sink shall be provided within reasonable distance from the food service department for its use, but it may be shared with other activities. Space near the utility sink shall be provided for the storage of brooms, mops, and cleaning materials.

F. Space. There shall be sufficient floor space in the food service department to permit all activities to function efficiently without overcrowding:

(1) New Construction. New construction providing a conventional type food service program shall have the following minimal space requirements (excluding bulk food-storage areas, dining areas, and separate floor pantries). Modification of the following minimum space will be made in the event that the facility can demonstrate that the use of convenience food, disposables, or equipment, require less space for operation. However, once a facility elects to use these procedures or systems and a modification is granted, the systems may not be changed without prior approval of the Department. The Department in these cases may require additional space to be provided.

<i>Homes' Licensed Capacity for Patients</i>	<i>Minimum Space</i>
(a) 2 to 10	120 square feet.
(b) 11 to 35	132 square feet plus 12 square feet per licensed bed in excess of 11.
(c) 36 to 100	430 square feet plus 10 square feet per licensed bed in excess of 36.
(d) over 100	1,070 square feet plus 8 square feet per licensed bed in excess of 100.

(2) Renovations of existing kitchens shall be approved by the Department which will consider modification of the minimum space requirement based on space available, costs, and type of service.

(3) Aisle space between working areas shall be at least 3 feet; main traffic shall be at least 5 feet.

(4) Ceiling height shall be at least 9 feet.

Agency Note: 10 foot ceiling height is recommended.

(5) Existing Facility. A facility which holds full licensure as of the adoption of these regulations shall be considered as

having an adequate size dietetic service department.

(6) If the licensed capacity of a facility is increased, or meals are provided to anyone outside of the facility from the food service area of the facility, the facility shall provide additional food service area in accordance with §F(1), (3), and (4) of this regulation. The additional food service area required when meals are provided to anyone outside of the facility is to be calculated by using the total number of individuals to whom meals are provided.

(7) The kitchen space requirement in §F(6) of this regulation does not apply to occasional special functions such as picnics or dinners for residents, volunteers, families, or community groups provided the facility certifies to the Department that the provision of meals for the particular special function will not adversely affect or detract from the timely provision of meals to the residents of the facility.

G. Floor Pantries—New Construction.

(1) In a decentralized food service, the area or areas for floor pantries shall be approved by the Department.

(2) This area shall be of sufficient size to accommodate the equipment required for food preparation and service.

Agency Note: The following equipment is recommended:

- (a) Equipment to maintain food at correct temperature;
- (b) Toaster;
- (c) Hot plate;
- (d) Refrigerator;
- (e) Ice-making machine or ice-storage container;
- (f) Work space for tray preparation;
- (g) Equipment for delivery of completed trays;
- (h) Three-compartment sink or dishwasher;
- (i) Cabinet for dry storage and supplies;
- (j) Storage for trays, tableware, flatware, and utensils;
- (k) Handwashing sink with soap and towel dispenser or approved drying device.

(3) At least one nourishment pantry convenient to the nursing station shall be provided on each floor in facilities using a centralized food service system. Minimum equipment shall include the following:

- (a) Refrigerators;
- (b) Cabinets for dry storage and supplies;
- (c) Work space;
- (d) Sink for purposes other than handwashing;
- (e) Handwashing sink with soap and towel dispenser or approved drying device.

H. Equipment for Food Preparation and Distribution. The following requirements shall be met:

(1) Adequate equipment for preparation, serving, and distribution of food shall be provided;

(2) A dumbwaiter, elevator, or ramp shall be provided in a facility of more than one story where more than eight patients, above or below the kitchen level, receive bedside tray service;

(3) Equipment to protect food from dust or contamination and to maintain food at proper temperature shall be provided for transportation of food to the patients.

I. Dry Food Storage. The following requirements shall be met:

(1) Adequate space shall be provided for the storage of food supplies;

Agency Note: The amount of storage space needed is dependent upon frequency of deliveries. It is recommended that 2 square feet per patient be provided and that the area be located within easy access to the receiving area and the kitchen.

(2) The storeroom shall be cool and well ventilated;

(3) All food supplies shall be stored off the floor and away from the wall to allow for cleaning.

Agency Note: Care should be exercised in the rotation of stored food so that old stock is used first.

J. Refrigerated Storage. Adequate refrigerated storage, refrigerators and frozen food storage cabinets, shall be provided which are regulated to maintain temperatures prescribed in COMAR 10.15.03 Food Service Facilities.

.33 Administrative Areas.

A. **New Construction.** In new construction, a separate room or rooms shall be provided for the administrator and staff. Sufficient areas shall be provided to accommodate all necessary office furniture, files, and other equipment, including provision for the safe storage of patients' valuables.

B. **Existing Facilities.** In existing facilities, an administrative area shall be provided which is suitable for conducting business or discussing in privacy problems with the patient's sponsor.

C. **Lobby Area.** In new construction, facility shall provide a lobby area. Public toilets for both sexes shall be located conveniently to this area. Telephone service and drinking fountains which meet ANSI standards also shall be provided.

D. **Employee Facilities—New Construction.** In new construction, separate locker rooms and toilet facilities shall be provided for male and female employees in each facility.

E. **Employee Facilities—Existing Facilities.** In existing facilities a sufficient number of lockers capable of being securely locked shall be provided for all employees working at any one time, and provision shall be made for the use of toilet facilities at a convenient location.

.34 Housekeeping Services, Pest Control, and Laundry.

A. Staff. Sufficient housekeeping and maintenance personnel shall be employed to maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner.

B. Cleanliness and Maintenance. The following shall be observed:

(1) The building and all its parts and facilities shall be kept in good repair, neat and attractive. The safety and comfort of the patients shall be the first consideration.

(2) All walls, floors, ceilings, windows, and fixtures shall be kept clean. Interior walls and floors shall be of a character to permit frequent and easy cleaning.

(3) The facility shall be kept free of unnecessary accumulations of personal possessions, boxes, trunks, suitcases, papers, unused furniture, bed clothing, linens, bric-a-brac, and similar items.

(4) The grounds shall be kept clean, neat, attractive, and free of hazards.

(5) The facility shall be maintained free of insects and rodents by operation of an active pest-control program, either by use of maintenance personnel or by contract with pest-control company. Care shall be exercised in the usage and storage of toxic and flammable insecticides and rodenticides. Usage shall conform to the U.S. Environmental Protection Administration and Maryland Department of Agriculture requirements.

Agency Note: Refer to Regulation .26S of this chapter for window screening requirements.

C. Laundries-New Facilities. In laundries in new facilities there shall be a physical separation between the "clean" and "soil" areas. There shall be provision for the laundering of patients' clothing. Hot water temperatures in laundries shall conform to applicable standards of the International Fabric Care Institute for laundry water supply.

D. Laundries-Existing Facilities. In existing facilities where a physical separation is not possible, exceptions as to approved laundry facilities may be made at the discretion of the Department. There shall be provision for the laundering of patients' clothing. Hot water temperatures in laundries shall conform to applicable standards of the International Fabric Care Institute for laundry water supply.

.35 Resident Care Management System.

A. Each comprehensive care facility and extended care facility shall establish and maintain a resident care management system.

B. The resident care management system shall be comprised of three interrelated components:

- (1) Resident status assessment and data gathering;
- (2) Care planning; and
- (3) Actions in response to care plan approaches.

.36 Resident Status Assessment.

A. Disciplines shall record all assessments on a form approved by the Department.

B. State Operations Manual for Provider Certification, Appendix R—Resident Assessment Instrument for Long-Term Care Facilities, Transmittal No. 272, April 1995 and Transmittal No. 22, December 2000, U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, is incorporated by reference.

C. A facility shall use the following forms and procedures for resident assessment as described in the State Operations Manual for Provider Certification:

(1) Minimum Data Set (MDS) version as determined by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, in Transmittal No. 22, referenced in §B of this regulation;

(2) Resident Assessment Protocol Summary;

(3) MDS Quarterly Assessment Form;

(4) Maryland Monthly Assessment; and

(5) Care plans.

D. The facility shall complete all assessments in accordance with the provisions of 42 CFR §§483.20 and 413.343.

E. All facilities certified for participation in Medicare or Medicaid shall complete and electronically submit the assessment to the Department not later than 31 days after completion of the assessment.

F. A facility as a comprehensive or extended care facility but not certified for participation in the Medicare or Medicaid Program shall comply with the State Operations Manual for Provider Certification, except that data may not be electronically submitted to the Department.

.37 Care Planning.

A. An interdisciplinary team shall complete a resident specific care plan for each resident within 7 calendar days following completion of all assessments.

B. A care plan under this regulation shall be based upon assessments conducted at the following times:

- (1) Admission;
- (2) Annual;
- (3) Quarterly; and
- (4) Significant change in the resident's condition.

C. A facility shall give a family member or resident's representative 7 calendar days advance notice, in writing, of the location, date, and time of the care planning conference for a resident for whom a family member or representative is interested. The notification shall include an invitation for the family member or resident's representative to attend the conference.

D. The facility shall hold the care planning conference not later than 7 calendar days after completion of the assessment, but may hold the conference earlier if agreed to by the resident, a family member, or a resident's representative.

E. Organization of Care Plan.

(1) Problems and needs shall be identified, based upon the interdisciplinary assessment. The care plan shall address all of the resident's special care requirements necessary to improve or maintain the resident's status. The interdisciplinary team shall incorporate resident input into the care plan.

(2) The team shall establish goals for each problem or need identified. The goal shall be realistic, practical, and tailored to the resident's needs. Goal outcome shall be measurable in time or degree, or both.

(3) Approaches to accomplishing each goal shall be established. Approaches shall communicate the work to be done, by whom it is to be done, and how frequently it is to be performed.

F. Disciplines shall update the care plans as the resident's assessment warrants, but not less than quarterly.

G. Availability of Resident Care Plan. Resident care plans shall be readily available for use by all health care personnel.

.38 Special Skin Record.

- A. The facility shall establish a skin care record documenting skin, hair, and nail condition on admission, if any abnormal conditions exist.
- B. The staff shall document progression of the condition or conditions weekly until the condition or conditions have healed.
- C. At any time that a skin condition persists for more than 7 days, staff shall add the condition to the skin record.

.39 Geriatric Nursing Assistant Program.

A. Facility Responsibilities.

(1) Each facility shall conduct or arrange a nurses' aide training program for unlicensed personnel assigned direct patient care duties. This requirement does not extend to physical or occupational therapy assistants or to other employees performing delegated, non-nursing functions. The facility may use an outside program if it has been reviewed and approved by the Department.

(2) Each facility shall submit a written proposal to the Department for satisfying the developmental training program requirement.

(3) A nurse aide is deemed to satisfy the requirements of this chapter if that individual has successfully completed a training program approved by the State before July 1, 1990, or has been "grandfathered" under previous regulations.

(4) Other persons hired as nurse aides after July 1, 1990 shall complete an approved program within 120 days of employment.

(5) The facility shall record the satisfactory completion of the program in each employee's personnel record. A certificate evidencing completion of the program shall be issued to the employee. The signature of the program's teacher or trainer shall be required for authentication.

B. Course Structure.

(1) Effective with employees hired on or after July 1, 1990, the training program course shall consist of 75 hours or more, and include at least 37.5 hours of classroom instruction and not less than 37.5 hours of supervised clinical experience in long-term care.

(2) The course content shall adhere to the Geriatric Nursing Assistant Program curriculum in Regulation .40 of this chapter.

(3) The course instructor shall have overall supervisory responsibility for the operation of the program, and shall:

(a) Be a registered nurse licensed in Maryland;

(b) Have at least 2 years of nursing experience, at least 1 year of which shall have been in caring for the elderly or chronically ill in the past 5 years; and

(c) Have attended a program of instruction in training methodologies approved by the Department.

(4) Supplementary instructors shall be drawn from qualified resource personnel such as registered nurses, licensed practical/vocational nurses, pharmacists, dieticians, social workers, sanitarians, fire safety experts, nursing home administrators, gerontologists, psychologists, physicians, physical and occupational therapists, activities specialists, speech/language/hearing therapists, and residents' rights experts, as well as persons with relevant experience, such as residents or experienced aides.

(5) Adequate numbers of instructors are required to ensure that each trainee is provided effective assistance and supervision which does not endanger the safety of residents.

(6) Each training program shall have behaviorally stated objectives for each unit of instruction, stating measurable performance criteria.

(7) Each trainee shall be clearly identified as a trainee during all skills training portions of the training.

(8) During training, a trainee may provide only that care for which the trainee has demonstrated competency to the satisfaction of the appropriate program instructor.

(9) An orientation program shall be provided to trainees for a nursing facility in which training is to occur. This program shall consist of:

- (a) An explanation of organizational structure, policies, and procedures;
- (b) Discussion of the philosophy of care;
- (c) Description of the resident population; and
- (d) Employee rules.

(10) The orientation may not be included in the required 75 hours of the training course.

(11) A training program shall provide at least 16 hours of training prior to a trainee's direct assignment to resident care. This instruction shall include the following topics:

- (a) Infection control;
- (b) Safety and emergency procedures;
- (c) Promoting residents' independence;
- (d) Respecting residents' rights; and
- (e) Communication and interpersonal skills.

.40 Curriculum for the Geriatric Nursing Assistant Program.

A. Introduction.

- (1) Role of nursing assistant;
- (2) Relationships of nursing assistant to health care team;
- (3) Purpose of long-term care;
- (4) Patient's rights.

B. Approaches of Caring for the Aging Patient.

- (1) Observation/reporting:
 - (a) Changing function and behavior--normal vs. abnormal,
 - (b) Confidentiality;
- (2) Communication:
 - (a) Forms (examples, body language, verbal and nonverbal),
 - (b) Patient, family and staff;
- (3) Cultural and social needs:
 - (a) Background—past/present views,
 - (b) Social myths and prejudice;
- (4) Spiritual needs;
- (5) Family's needs and reaction.

C. Patient Environment.

- (1) Safety:
 - (a) Protective devices/restraints,
 - (b) Fire and disaster;
- (2) Infection control:
 - (a) Handwashing;
 - (b) Signs and symptoms of common communicable disease;
 - (c) Basics in isolation techniques;
- (3) Maintaining the patient room:
 - (a) General environmental cleanliness;
 - (b) Age-related consideration (for example, temperature, glare, noise);
- (4) Equipment:

- (a) Storage,
- (b) Use,
- (c) Preventive maintenance.

D. Basic Skills. These skills will require instruction, demonstration, and return demonstration by each student.

(1) Bedmaking:

- (a) Supplies,
- (b) Occupied/unoccupied,
- (c) Method,
- (d) Handling of linens (clean and dirty);

(2) Personal grooming:

(a) Baths:

- (i) Types,
- (ii) Supplies,
- (iii) Nail care,
- (iv) Foot care,
- (v) Hair care;

(b) Oral hygiene:

- (i) Importance,
- (ii) Equipment,
- (iii) Procedure,
- (iv) Special care;

(3) Feedings:

- (a) Types,
- (b) Assisting,
- (c) Independent,
- (d) Complete;

(4) Bedpans and urinals:

- (a) Precautions,
- (b) Positioning;

(5) Body mechanics:

- (a) Transfer:
 - (i) Equipment,

- (ii) Principles,
- (iii) Types;
- (b) Positioning:
 - (i) Bed,
 - (ii) Chair.

E. Intermediate Skills. These abilities will require instruction, demonstration, and return demonstration by each student.

- (1) Ambulation:
 - (a) Walker,
 - (b) Cane;
- (2) Enemas:
 - (a) Types,
 - (b) Positioning;
- (3) Collection and types of specimens (urine, stool, and sputum);
- (4) Intake and output—observation and recording;
- (5) Vital Signs:
 - (a) Temperature,
 - (b) Pulse,
 - (c) Respirations,
 - (d) Height,
 - (e) Weight,
 - (f) Blood pressure;
- (6) Terminal care:
 - (a) Dying vs. death,
 - (b) Family—present and past,
 - (c) Personal possessions,
 - (d) Cultural benefits,
 - (e) Postmortem care.

F. Advance Skills. These skills will require instruction, demonstration, and return demonstration by each student.

- (1) Bowel and bladder training;
- (2) Range of motion;
- (3) Reality orientation;
- (4) Patient care planning implementation;

- (5) Oxygen;
- (6) Emergency procedures;
- (7) Decubitus care and prevention;
- (8) Feeding tube care;
- (9) Catheter care and positioning of tube for drainage;
- * (10). Impactions—observation and removal;
- * (11) Colostomy/ileostomy/ileo-conduit;
- (12) Hot and cold applications;
- * (13) Sitz baths.

----- * Optional procedures.

G. Principles of Body Systems. Objectives of this unit will be to present a basic overview of each system as it relates to patient limitation/condition/disease.

- (1) Circulatory;
- (2) Respiratory;
- (3) Muscular and skeletal;
- (4) Sensory/neurological;
- (5) Metabolic/endocrine;
- (6) Urinary;
- (7) Gastrointestinal;
- (8) Skin.

H. Dementia. Objectives of this unit will be to enable students to identify and describe behavior and symptoms of dementia, to recognize and report changes in behavior to supervisors, to assist cognitively impaired patients with activities of daily living including personal care and ambulation with the least possible behavior disruptions, to maintain a safe environment for patients with dementia, and to intervene appropriately in behavioral manifestations of dementia.

- (1) Introduction.
 - (a) Definition of dementia disease process;
 - (b) Misconceptions;
 - (c) Causes:
 - (i) Irreversible,
 - (ii) Reversible;
 - (d) Delirium:
 - (i) Recognizing delirium to differentiate delirium from dementia;
 - (ii) Causes.

(2) Behaviors and Symptoms.

(a) Specific behaviors:

- (i) Aggressiveness,
- (ii) Agitation/screaming,
- (iii) Catastrophic,
- (iv) Hallucinations/delusions,
- (v) Inappropriate sexual behavior,
- (vi) Limited attention span,
- (vii) Resistive behavior,
- (viii) Rummaging and hoarding,
- (ix) Suspiciousness,
- (x) Wandering;

(b) Related behaviors:

- (i) Anxiety,
- (ii) Demanding,
- (iii) Depression/withdrawal,
- (iv) Irritability,
- (v) Sleep changes.

(3) Psychosocial Aspects.

- (a) Impact on family;
- (b) Impact on other residents;
- (c) Coping with losses;
- (d) Staff stress and its management.

(4) Responses to Behaviors. Each behavior shall include a description of the behavior, what to report and when to report, to whom to report, and management aspects (environment, communication, social/activities, physical management).

.41 Paid Feeding Assistants.

A. A facility may use a paid feeding assistant who has successfully completed a State-approved training course as described in §E of this regulation.

B. Supervision.

(1) A paid feeding assistant shall work under the supervision of a licensed nurse.

(2) In an emergency, when the resident is fed in the resident's room, a paid feeding assistant shall use the resident call system to call a supervisory nurse for help.

C. A facility that uses a paid feeding assistant shall ensure that the paid feeding assistant feeds only residents who do not have complicated feeding conditions including, but not limited to:

(1) Difficulty swallowing;

(2) Choking;

(3) Recurrent lung aspirations; or

(4) Tube or parenteral intravenous feedings.

D. Protocol. The facility shall develop a protocol for selecting residents who are appropriate for feeding by a paid feeding assistant. The facility shall select a resident based on the:

(1) Charge nurse's current assessment of the resident;

(2) The resident's latest Minimum Data Set (MDS) assessment; and

(3) The resident's plan of care.

E. State-Approved Training. A State-approved training course for paid feeding assistants shall consist of at least 8 hours of training that includes:

(1) Feeding techniques;

(2) Assistance with feeding and hydration;

(3) Communication and interpersonal skills;

(4) Appropriate responses to resident behavior;

(5) Safety and emergency procedures, including the Heimlich maneuver;

(6) Infection control;

(7) Resident rights;

(8) Recognizing changes in a resident's behavior that are inconsistent with the resident's normal behavior and the importance of reporting these changes to a supervisory nurse; and

(9) Successful completion of a two-part test that includes a:

(a) Written test with a passing score of 80 percent; and

(b) Demonstration of proper feeding skills performed on a resident under observation.

F. The feeding assistant training may be taught by a:

- (1) Registered nurse and supplementary professional instructors;
- (2) Licensed dietitian-nutritionist;
- (3) Licensed physical therapist;
- (4) Licensed speech therapist; or
- (5) Licensed occupational therapist.

G. The facility shall maintain a record of all paid feeding assistants who have successfully completed a feeding assistance course.

.42 Geriatric Nursing Assistant Program — Competency Evaluation and Registry.

A. Geriatric Nursing Assistant Competency Evaluation.

(1) The Department shall provide for the evaluation and certification of the competency of geriatric nursing assistants.

(2) The Department will approve one or more competency evaluation programs meeting the criteria set forth by the Health Care Financing Administration of the United States Department of Health and Human Services for registration of nursing aides under Titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act.

(3) On or after October 1, 1990, a comprehensive care facility may not employ an individual in the capacity of geriatric nursing assistant unless the individual has successfully completed a competency evaluation approved by the Department, except as provided in Regulations .39A(1) and (3) and .41B of this chapter. The competency evaluation shall consist of two parts, which are a written evaluation and a clinical skills evaluation.

(4) On or after October 1, 1990, an individual shall be reregistered as a geriatric nursing assistant if there has been a continuous period of 24 months during which the individual did not provide nursing assistant duties for monetary compensation since the individual's last registration.

B. Geriatric Nursing Assistant Registry.

(1) The Department shall establish and maintain a registry of geriatric nursing assistants properly certified to work in that capacity in comprehensive care facilities or extended care facilities in Maryland.

(2) Individuals possessing proof of out-of-State registration as a geriatric nursing assistant as provided under Regulation .41B of this chapter shall submit proof of that registration to the Department in order to be listed in the geriatric nursing assistant registry in Maryland.

(3) Except as provided in Regulation .39A(3) of this chapter, after the establishment of a registry, a nursing facility may not employ an individual as a geriatric nursing assistant who is not listed in the registry.

(4) The registry shall include the following information concerning individuals listed:

(a) Full name, including maiden name and other surnames used;

(b) Address at the time the competency evaluation is passed;

(c) Date of birth;

(d) Social Security number;

(e) Name of training program and date of completion;

(f) An individual's last known employer and the date of hiring and termination by the employer;

(g) Date or dates of competency evaluation and date of successful completion of competency evaluation;

(h) Any findings documented by the Department of resident neglect or abuse, or misappropriation of resident property involving an individual listed in the registry; and

(i) A brief statement disputing the findings in §B(4)(h), of this regulation, by an individual, if the individual makes a statement.

(5) Before any finding is included in the registry, the Department shall notify the individual involved, and permit the individual to appeal the finding. The appeal shall be filed within 30 days of the notification by the Department. If an appeal is filed in a timely manner, the finding may not be included until a decision by the Secretary that the inclusion of the findings is appropriate.

(6) A person participating in good faith in these activities is not civilly liable under the provisions of Health-General Article, §19-347(g), Annotated Code of Maryland.

(7) Information contained in the registry shall be considered public information under the Maryland Public Information Act and in accordance with federal law.

(8) Renewal and updating of a geriatric aide's registration is required every 2 years on a schedule set by the State.

(9) Registration fees may be charged to the individual to be listed in the registry.

.43 Medicine Aide — Scope of Responsibility.

A. Upon successful completion of the Department of Health and Mental Hygiene approved Medicine Aide Course, and when applicable, the continuing education course, the medicine aide may perform all medication administration functions except for those prohibited in §B of this regulation. These functions, including the following delegated nursing functions may only be performed by the aide under the direct supervision of a registered nurse or licensed practical nurse:

- (1) Prepare, administer and chart oral, topical and suppository drugs;
- (2) Perform pulse and blood pressure measurements;
- (3) Administer PRN medicines under the following directive:

(a) For non-legend PRN drugs, the medicine aide administers under the supervision of a registered nurse or licensed practical nurse,

(b) For legend drugs, the medicine aide shall inform the charge nurse, who shall first make a bedside assessment, and a written documentation of that assessment, before giving permission to a medicine aide to administer that medication;

- (4) Sign and have access to the controlled schedule drug cabinet; and
- (5) Administer drugs only with a written order.

B. The medicine aide shall be prohibited from performing the following duties:

- (1) Transcribing doctors' original orders to medicine charts or Kardexes;
- (2) Administering any parenteral medications;
- (3) Administering any substances by nasogastric or gastrostomy tubes; and
- (4) Receiving instructions for or being placed in charge level responsibilities.

C. On or after October 1, 1990, a medicine aide shall meet all applicable requirements of Regulations .39—.42, of this chapter, in addition to the requirements of this regulation.

.44 Medicine Aide Course Requirements.

A. Successful course completion will be recognized by the Department when:

(1) Before admission to the program, the applicant meets the following requirements:

(a) Possesses at least 1 year of full-time experience or its equivalent as a nursing assistant in a comprehensive care facility or extended care facility in Maryland;

(b) Evidences experience in basic patient care procedures; and

(c) Is currently employed as a geriatric nursing assistant in a comprehensive care facility or extended care facility.

(2) The curriculum satisfies the following model requirements:

(a) Is 60 hours in duration and gives equal weight to the theoretical and supervised clinical experience components;

(b) Includes each of the following pertinent subjects:

(i) Responsibilities and limitations of the medicine aide,

(ii) Drug standards, references and resources,

(iii) Legislation concerning drug utilization,

(iv) Characteristics of the elderly client (or exceptional) client-mentally retarded, multiple handicap:

(aa) Sources and purpose of drugs,

(bb) Dosage forms and methods of administration,

(cc) Drug life,

(dd) The medication order,

(ee) The administration of non-parenteral medications,

(ff) Procedures and techniques for administering drugs,

(gg) Drug classification, related health problems, and patient care responsibilities,

(hh) Drug solutions and their measurements, and

(ii) Monitoring for side effects of drugs and drug interactions.

B. As evidence of successful completion, the applicant shall possess a certificate issued to the applicant by the community college. Certificates issued by the community college shall remain valid proof of certification until June 30th of the second year following the date of issuance.

C. Certification beyond the initial two-year period is predicated upon the satisfactory completion of an 8-hour continuing education course designed as follows:

(1) A three-hour core content identifying:

(a) Current State regulations related to the role of the medicine aide;

(b) Uses, actions, related precautions, and possible interactions of current medications used in the care of the geriatric patient;

(c) New care procedures; and

(d) Resources available to the medicine aide which clarify and expand the knowledge of the medicine aide.

(2) Three hours on topics selected from the following:

(a) Documentation;

(b) Nutrition;

(c) The physiological system of the geriatric patient;

(d) Deinstitutionalization of the mentally retarded and psychiatric patient; or

(e) Other aspects of pharmacology.

(3) Two hours of assessment testing administered at the completion of the continuing education course.

(4) Each renewed certification shall be valid for a period of 2 years, until June 30th of the second year, following the satisfactory completion of the continuing education course.

D. An individual who has received a certificate evidencing completion of a program which the Department approved before the adoption of these regulations shall be deemed to meet the training requirements of this regulation.

.45 Quality Assurance Program.

A. By January 1, 2001, each nursing facility shall establish an effective quality assurance program that includes components described in this regulation and Regulation .46 of this chapter.

B. The nursing facility shall appoint a qualified individual to manage quality assurance activities within the nursing facility.

C. The nursing facility shall establish a quality assurance committee that includes at least:

- (1) A director of nursing;
- (2) An administrator;
- (3) A social worker;
- (4) A medical director;
- (5) A dietitian; and
- (6) A geriatric nursing assistant of the facility.

D. The Quality Assurance Committee. The quality assurance committee shall:

- (1) Designate a chairperson to manage committee activities;
- (2) Meet monthly to accomplish quality assurance activities;
- (3) Assist in developing and approve the facility's quality assurance plan;
- (4) Submit the quality assurance plan to the Department's Office of Health Care Quality at the time of licensure or at the time of license renewal;
- (5) Submit any change in the quality assurance plan to the Office of Health Care Quality within 30 days of the change;
- (6) Review and approve the facility's quality assurance plan at least yearly; and
- (7) Prepare monthly reports for the ombudsman, family council, and residents' council.

E. Quality Assurance Records. For the purposes of ensuring implementation and effectiveness of the quality assurance program, the facility shall make quality assurance records and documents available to the Office of Health Care Quality.

.46 Quality Assurance Plan.

A. The facility's quality assurance committee shall develop and implement a quality assurance plan that includes procedures for:

- (1) Concurrent review;
- (2) Ongoing monitoring;
- (3) Patient complaints;
- (4) Accidents and incidents; and
- (5) Abuse and neglect.

B. Concurrent Review. The quality assurance plan shall include:

- (1) The procedures for conducting concurrent review of each resident including:
 - (a) Criteria to determine any change in a resident's condition;
 - (b) A method to document the concurrent review; and
 - (c) Identification of the licensed nurse or nurses conducting the concurrent review;
- (2) The procedures to evaluate clinical data for any resident with a change in condition including at least:
 - (a) Medications;
 - (b) Laboratory values;
 - (c) Intake and output;
 - (d) Skin breakdown;
 - (e) Noted weights;
 - (f) Appetite;
 - (g) Injuries resulting from accidents or incidents; and
 - (h) Any other relevant parameters that may affect the resident's physical or mental status;
- (3) Procedures to take action when there is a change in the resident's condition; and
- (4) Procedure for referral of data to the quality assurance committee, when appropriate.

C. Ongoing Monitoring. The quality assurance plan shall include:

- (1) A description of the measurable criteria for ongoing monitoring of all aspects of resident care including:
 - (a) Medication administration;
 - (b) Prevention of decubitus ulcers, dehydration, and malnutrition;
 - (c) Nutritional status and weight loss or weight gain;
 - (d) Accidents and injuries;
 - (e) Unexpected death; and

- (f) Changes in physical or mental status;
- (2) The methodology for collection of data;
- (3) The methodology for evaluation and analysis of data to determine trends and patterns;
- (4) A description of the thresholds and performance parameters that represent acceptable care for the measured criteria;
- (5) Time frames for referral to the quality assurance committee;
- (6) A description of the plan for follow-up to determine effectiveness of the recommendations; and
- (7) A description of how the quality assurance activities will be documented.

D. Patient Complaints. The quality assurance plan shall include:

- (1) A description of a complaint process that effectively addresses resident or family concerns including:
 - (a) The designated person or persons and their phone numbers to receive complaints or concerns;
 - (b) The method to be used to acknowledge complaints received; and
 - (c) The time frames for investigating complaints dependent upon the nature or seriousness of the complaint;
- (2) A description of a logging system that will be used including the:
 - (a) Name of the complainant;
 - (b) Date the complaint was received;
 - (c) Nature of the complaint; and
 - (d) Date that the complainant was notified of the disposition or resolution of the complaint; and
- (3) The procedures for:
 - (a) Notifying residents of their right to file a complaint with the Office of Health Care Quality;
 - (b) Informing residents, families, or guardians of the complaint process upon admission; and
 - (c) Posting the complaint process or making it available without the need to request it.

E. Accidents and Injuries. The quality assurance plan shall include:

- (1) A definition of accident and injury that is appropriate to the type of resident served by the nursing home;
- (2) A description of the process for reporting accidents and injuries including:
 - (a) Who shall report incidents;
 - (b) The time frame for reporting incidents; and
 - (c) The procedure for reporting incidents;
- (3) A policy statement that includes a provision that reporting incidents can be done without fear of reprisal;
- (4) A description of how internal investigations of accidents and injuries will be handled including:
 - (a) Assessment of any injury;
 - (b) Interview of the resident, staff, and witness;
 - (c) Review of any relevant records including the resident's medical records, discharge summary, hospital records, etc.;

and

(d) Time frames for conducting the investigation;

(5) A description of the process for notifying family or guardian about the incident;

(6) A description of a process for the ongoing evaluation of accidents and injuries to determine patterns and trends; and

(7) A description of how relevant information will be referred to the quality assurance committee.

F. Abuse and Neglect. The quality assurance plan shall include:

(1) The process for implementing COMAR 10.07.09.15 concerning abuse of residents;

(2) A description of the process for providing immediate notification to the family, guardian, or responsible party about the incident;

(3) A description of the process for the ongoing evaluation of validated incidents of abuse and neglect to determine patterns and trends; and

(4) A description of how relevant information will be referred to the quality assurance committee.

.47 Relocation of Residents.

A. The facility shall develop and implement a written plan to provide for the smooth and orderly transfer of residents if the facility closes.

B. The plan for relocation shall include:

- (1) A description of how residents, families, or guardians will be notified and by whom;
- (2) Sample letters and other documents that will be used during a closure;
- (3) Procedures for notifying Medicaid and other payment sources;
- (4) Procedures for notifying the Office of Health Care Quality; and
- (5) A mechanism to ensure the safe and orderly transfer of residents that takes into account:
 - (a) Roommates, medical care, religious affiliation, geographical location and payer source;
 - (b) Proper assessment and identification of any special needs;
 - (c) Transfer of medical information and records; and
 - (d) Transfer of personal property.

.48 Posting of Staffing.

A. A nursing home shall post on each floor or unit of the nursing home, for each shift, a notice that explains the ratio of licensed and unlicensed staff to residents.

B. The posting on each floor shall include:

- (1) Names of the staff members on duty and the room numbers of the residents that each is assigned;
- (2) Name of the charge nurse or person in charge of the unit; and
- (3) Name of the medicine aide or person responsible for medication administration.

C. The posting shall be on a form provided or approved by the Department.

.49 Sanctions.

A. If a deficiency exists, the Department, in addition to the sanctions set forth in this regulation and Regulations .50—58 of this chapter, may:

- (1) Restrict the number of residents the nursing facility may admit in accordance with Health-General Article, §19-328, Annotated Code of Maryland;
- (2) Require the establishment of an escrow account in accordance with Health-General Article, §19-362, Annotated Code of Maryland;
- (3) Direct the licensee to correct the deficiencies in a specific manner or within a specific time frame, or both, to protect the health and welfare of residents;
- (4) Enter into an agreement with the licensee establishing certain conditions for continued operation, including time limits for compliance; and
- (5) In accordance with Health-General Article, §19-1405, Annotated Code of Maryland, appoint an independent State monitor who is qualified on the basis of education and experience to oversee correction of the deficiencies.

B. State Monitor.

- (1) The duties of the State monitor shall be specified in a written agreement between the Department and the State monitor and shall include but are not limited to:
 - (a) Conducting periodic on-site inspections to assess a nursing facility's compliance with State and federal regulations;
 - (b) Making recommendations to achieve compliance with State and federal regulations; and
 - (c) Issuing written reports to the Department and the nursing facility detailing the findings of the on-site inspections and the status of recommended actions that the facility shall complete to achieve compliance.
- (2) The State monitor shall function for a period of time specified by the Department. The facility may request rescission or modification of the duration of the State monitor's appointment at intervals of not less than 120 days from the date of appointment.
- (3) The State monitor may not be an employee of the Department.
- (4) The State monitor's salary shall be:
 - (a) Paid directly by the nursing facility; and
 - (b) At least equivalent to the prevailing salary paid by nursing facilities for an individual with similar education and experience.

C. If the Secretary determines that the licensee has violated a condition or requirement of an imposed sanction, the Secretary may revoke the license as permitted by applicable law.

D. A licensee aggrieved by the imposition of a sanction under §A(1) or (5) of this regulation may appeal the Secretary's action by filing a request for a hearing in accordance with Regulation .59 of this chapter. A licensee aggrieved by the imposition of a sanction under §A(2) of this regulation may appeal the Secretary's action in accordance with Health-General Article, §§19-364 and 19-367, Annotated Code of Maryland.

.50 Mandated Staffing Pattern.

A. When the Department determines that a deficiency or deficiencies exist, the Department shall notify the nursing facility of the deficiency or deficiencies and may either:

- (1) Mandate a staffing pattern which specifies the number of personnel or personnel qualifications, or both; or
- (2) Permit the facility the opportunity to correct the deficiencies by a specific date.

B. If the facility does not correct the deficiency or deficiencies, the Department has the authority to specify the number of personnel or personnel qualifications, or both.

C. The facility shall comply with the Department's mandated staffing pattern and notify the Department, in writing, when the staffing pattern has been implemented.

D. A mandated staffing pattern shall be in effect for the period of time specified by the Department. A facility may request rescission or modification of the staffing pattern at intervals of not less than 60 days from the date of imposition of the staffing pattern.

E. A facility has the right to appeal a mandated staffing pattern in accordance with State Government Article, Title 10, Subtitle 2, Annotated Code of Maryland. However, the mandated staffing pattern shall be maintained during the pendency of the appeal.

.51 Civil Money Penalties — Imposition.

A. A civil money penalty may be imposed when:

- (1) A deficiency exists; or
- (2) An ongoing pattern of deficiencies exist in a nursing facility.

B. In determining whether a civil money penalty is to be imposed, the Department shall consider the following factors:

- (1) The number, nature, and seriousness of the deficiencies;
- (2) The extent to which the deficiency or deficiencies are part of an ongoing pattern during the preceding 24 months;
- (3) The degree of risk to the health, life, or safety of the residents of the nursing facility caused by the deficiency or deficiencies;
- (4) The efforts made by, and the ability of, the nursing facility to correct the deficiency or deficiencies;
- (5) A nursing facility's prior history of compliance in general and specifically with reference to the cited deficiencies; and
- (6) Such other factors as justice may require.

C. When the Department determines that a deficiency or an ongoing pattern of deficiencies exists, the Department shall notify the nursing facility of the deficiency or deficiencies and may:

- (1) Impose a per day civil money penalty until sustained compliance has been achieved;
- (2) Permit the facility the opportunity to correct the deficiencies by a specific date; or
- (3) Impose a per instance civil money penalty for each instance of violation.

D. When the Department permits a facility the opportunity to correct the deficiencies by a specific date, and the facility fails to comply with this requirement, the Department may impose a per day civil money penalty for each day of violation until correction of the deficiency or deficiencies has been verified and sustained compliance has been maintained.

E. When a civil money penalty is imposed, the Department shall issue an order which includes the:

- (1) Deficiency or deficiencies on which the order was based;
- (2) Amount of civil money penalty to be imposed; and
- (3) Manner in which the amount of civil money penalty was calculated.

F. An order issued pursuant to §E of this regulation is void unless issued within 60 days of the inspection or reinspection at which the deficiency or deficiencies are identified.

.52 Civil Money Penalties — Amount of Penalty.

A. A civil money penalty imposed under this chapter for potential for more than minimal harm deficiencies may not exceed:

(1) \$10,000 per instance; or

(2) \$1,000 per day for an ongoing pattern of deficiencies until correction of the deficiencies has been verified and sustained compliance has been maintained.

B. A civil money penalty imposed under this chapter for actual harm deficiencies may not exceed:

(1) \$10,000 per instance; or

(2) \$5,000 per day for an ongoing pattern of deficiencies until correction of the deficiencies has been verified and sustained compliance has been maintained.

C. A civil money penalty imposed under this chapter for a serious and immediate threat may not exceed:

(1) \$10,000 per instance; or

(2) \$10,000 per day for an ongoing pattern of deficiencies until correction of the deficiencies has been verified and sustained compliance has been maintained.

D. In setting the amount of a civil money penalty, the Department shall consider the following factors:

(1) The number, nature, and seriousness of the deficiencies;

(2) The degree of risk to the health, life, or safety of the residents of the nursing facility caused by the deficiency or deficiencies;

(3) The efforts made by, and the ability of, the nursing facility to correct the deficiency or deficiencies;

(4) Current federal guidelines for civil money penalties;

(5) Whether the amount of the proposed civil money penalty will jeopardize the financial ability of the nursing facility to continue operating as a nursing facility;

(6) A nursing facility's prior history of compliance; and

(7) Such other factors as justice may require.

.53 Civil Money Penalties — Effective Date and Duration of Penalty.

A. Per Instance Civil Money Penalty. The effective date may be as early as the date that the deficiency or deficiencies upon which the civil money penalty is based first occurred.

B. Per Day Civil Money Penalty.

(1) The daily civil money penalty starts to accrue as of the date of the visit that identifies the deficiency or deficiencies upon which the civil money penalty is based.

(2) The accrual of the daily civil money penalty ceases when correction of the deficiency or deficiencies upon which the civil money penalty was based has been verified and the facility has maintained sustained compliance.

.54 Civil Money Penalties — Payment of Penalty/Establishment of Escrow Account.

A. A civil money penalty payment is due 15 calendar days after:

(1) The time period for requesting a hearing has expired and a request for hearing was not received; or

(2) Receipt of a written request from the facility to waive its right to a hearing and reduce the amount of the civil money penalty by 40 percent provided the written request is received by the Department within 30 calendar days of the Department's order imposing the civil money penalty.

B. Within 15 days of the request for an appeal by a nursing facility, the nursing facility shall deposit the amount of the civil money penalty in an interest-bearing escrow account. If a per day civil money penalty is in effect at the time the escrow account is established, the amount owed on that date shall be deposited into the escrow account. The nursing facility shall bear any cost associated with establishing the escrow account, and the account shall be titled in the name of the nursing facility and the Department of Health and Mental Hygiene as joint owners.

C. When the Secretary issues the final decision of the Department:

(1) If the decision upholds the imposition of the full civil money penalty, the escrow funds, in addition to the amount of any per day civil money penalty that has accrued after the initial deposit into the escrow account, shall be released to the Department within 15 days from the date of the decision;

(2) If the decision upholds the imposition of a civil money penalty, but reduces the amount of the civil money penalty, the amount due the Department shall be released to the Department with accrued interest within 15 days of the date of the decision and the balance will be released to the nursing facility within 15 days of the date of the decision; or

(3) If the decision reverses the imposition of the civil penalty, the escrow funds shall be released to the nursing facility with accrued interest within 15 days of the decision.

D. If a facility does not release or pay the civil money penalty to the Department after the Secretary has issued a final decision upholding the civil money penalty and after notice to the facility, the State may deduct the amount of the civil money penalty from any sum that is then or later owed by the State to the facility, pursuant to State Finance and Procurement Article, §7-222, Annotated Code of Maryland.

.55 Civil Money Penalties — Hearings.

- A. A licensee aggrieved by the imposition of a civil money penalty may appeal the action by filing a request for a hearing in accordance with State Government Article, Title 10, Subtitle 2, Annotated Code of Maryland.
- B. The Secretary has the burden of proof with respect to the imposition of civil money penalties.
- C. The Office of Administrative Hearings shall render a decision within 10 working days of the hearing.

.56 Criminal Penalties.

A. A person maintaining or operating a nursing facility without a license is guilty of a misdemeanor, and, on conviction, is liable for a fine of not more than \$1,000 for the first offense and not more than \$10,000 for each subsequent conviction. Each day that the nursing facility continues to operate without a license after the first conviction is a subsequent offense and may subject the operator to further criminal prosecution.

B. A person maintaining and operating a nursing facility that is in violation of this chapter is guilty of a misdemeanor, and, on conviction, shall be fined not more than \$1,000. Each day that the nursing facility operates after the first conviction, without correction of the cited violation, is considered a subsequent offense and may subject the operator to further prosecution.

.57 Emergency Suspension.

A. The Secretary may immediately suspend a license on finding that the public health, safety, or welfare imperatively requires emergency action pursuant to State Government Article, §10-405(b), Annotated Code of Maryland.

B. The Department shall deliver a written notice to the nursing facility:

(1) Informing the nursing facility of the emergency suspension;

(2) Giving the reasons for the action and the regulation or regulations with which the licensee has failed to comply that forms the basis for the emergency suspension; and

(3) Notifying the nursing facility of its right to request a hearing and to be represented by counsel.

C. The filing of a hearing request does not stay the emergency action.

D. When a license is suspended by emergency action:

(1) The nursing facility shall immediately return the license to the Department; and

(2) The licensee shall notify the residents or representatives of the residents of the suspension and make every reasonable effort to assist them in making arrangements for transfer to other appropriate living arrangements.

E. In the event of an emergency suspension, the Department may assist in the relocation of residents.

F. A person aggrieved by the action of the Secretary under this regulation may appeal the Secretary's action by filing a request for a hearing in accordance with Regulation .59 of this chapter.

G. The Office of Administrative Hearings shall conduct a hearing as provided in Regulation .59 of this chapter and issue a proposed decision within 10 business days of the close of the hearing record. Exceptions may be filed by an aggrieved person pursuant to COMAR 10.01.03. The Secretary shall make a final decision pursuant to COMAR 10.01.03.

H. If the Secretary's final decision does not uphold the emergency suspension, the nursing facility may resume operation.

.58 Denial or Revocation of License.

A. Denial or Revocation of License. The Secretary, for cause shown, may notify the nursing facility of the decision to revoke or deny the nursing facility's license. The denial or revocation shall be stayed if a hearing is requested.

B. The Department shall notify the nursing facility in writing of the following:

(1) The effective date of the denial or revocation;

(2) The reason for the denial or revocation;

(3) The regulations with which the licensee has failed to comply that form the basis for the denial or revocation;

(4) That the nursing facility is entitled to a hearing if requested, and to be represented by counsel;

(5) That the nursing facility shall stop providing services on the effective date of the denial or revocation if the nursing facility does not request a hearing;

(6) That the denial or revocation shall be stayed if a hearing is requested; and

(7) That the nursing facility is required to surrender its license to the Department if the denial or revocation is upheld.

C. The licensee shall notify the residents or residents' representatives of any final denial or revocation and make every reasonable effort to assist them in making other living arrangements. The Department may assist in the relocation of residents.

D. A person aggrieved by the action of the Secretary under this regulation may appeal the Secretary's action by filing a request for a hearing in accordance with Regulation .59 of this chapter.

.59 Hearings.

A. A request for a hearing shall be filed with the Office of Administrative Hearings, with a copy to the Office of Health Care Quality of the Department, not later than 30 days after receipt of notice of the Secretary's action. This request shall include a copy of the Secretary's action.

B. A hearing requested under this chapter shall be conducted in accordance with:

- (1) State Government Article, Title 10, Subtitle 2, Annotated Code of Maryland;
- (2) COMAR 28.02.01; and
- (3) COMAR 10.01.03.

C. The burden of proof is as provided in COMAR 10.01.03.28.

D. Unless otherwise stated in this chapter, the Office of Administrative Hearings shall issue a proposed decision within the time frames set forth in COMAR 28.02.01.

E. The aggrieved person may file exceptions as provided in COMAR 10.01.03.35.

F. A final decision by the Secretary shall be issued in accordance with COMAR 10.01.03.35.

.60 Health Care Quality Account.

A. The Department shall establish a health care quality account in the Department.

B. The health care quality account shall be funded by civil money penalties paid by nursing homes.

C. The Department shall use funds from the health care quality account to improve the quality of care in nursing facilities.

D. Expenditure of funds may include, but are not limited to the following:

(1) Funding for the establishment and operation of a demonstration project;

(2) A grant award;

(3) Relocation of residents in crisis situations;

(4) Provision of educational programs to nursing facilities, the Office of Health Care Quality, other government, professional, or advocacy agencies, and consumers; and

(5) Any other purpose that will directly improve quality of care.

E. Suggestions for the use of funds may be submitted to the Department from:

(1) Members of the public;

(2) Advocacy organizations;

(3) Government agencies;

(4) Professional organizations including trade associations;

(5) Nursing homes; and

(6) Nursing home associations.

F. Decision on Expenditure of Funds.

(1) The Department, in its sole discretion, shall decide how to spend funds from the health care quality account.

(2) The Department's decision to spend funds or not to spend funds for a specific project or purpose is not a contested case as defined in State Government Article, § 10-202(d), Annotated Code of Maryland, and therefore is not subject to appeal.

.61 Financial Disclosure.

A. A licensee shall have financial resources in accordance with this regulation in order to:

- (1) Satisfy obligations; and
- (2) Ensure at all times the delivery of essential care and services, such as nursing, dietary services, or utilities.

B. A licensee shall notify the Secretary of significant adverse changes in financial condition which reasonably could be anticipated to adversely affect the delivery of essential care and services. These adverse changes include, but are not limited to, the following situations:

(1) The facility fails to maintain the facility's utilities or a quantity of supplies, including nursing, dietary, pharmaceutical, or other care and service supplies, sufficient to meet the needs of the residents;

(2) The facility is unable to meet its employee payroll or benefits obligations;

(3) The license holder or entity legally authorized to act on behalf of the license holder receives notice that a judgment or tax lien of at least \$5,000 has been filed, recorded, or levied against the facility or any of the assets of the facility or the license holder and the judgment or tax lien is not satisfied, or an appropriate extension has not been obtained, within 30 days after receipt of the notice;

(4) A financial institution refuses to honor facility-operation-related checks or other financial instruments issued by the license holder or entity legally authorized to act on behalf of the license holder, and:

(a) The cumulative amount of the checks or financial instruments is \$5,000 or more; and

(b) The checks or financial instruments are not honored or replaced to the satisfaction of the holders of the instruments within 10 working days after the holders have notified the license holder, operator, administrator, manager, or the person authorized to issue the instrument of the dishonored items;

(5) The license holder, or entity legally authorized to act on behalf of the license holder fails to make timely payments of any facility-related tax of at least \$1,000, and fails to satisfy the tax within 30 working days after the date the tax becomes delinquent;

(6) The license holder, owner of 25 percent of the license holder's assets, or facility management company files a voluntary bankruptcy petition, or a creditor files an involuntary bankruptcy petition against the facility management company, license holder, or owner of 25 percent or greater of the license holder's assets;

(7) A court appoints a bankruptcy trustee for the facility;

(8) A person seeking appointment of a receiver for the facility files a petition for the appointment of a receiver for the facility in any jurisdiction;

(9) The license holder, or person legally authorized to act on behalf of the license holder is unable to meet conditions of a facility-operation-related loan or material debt covenant unless the loan or material debt covenant has been waived or cured, and that inability has led to a recall by the issuing entity; or

(10) The license holder, or entity legally authorized to act on behalf of the license holder, is delinquent on more than \$5,000 of facility-related contractual obligations or vendor contracts that affect essential care and services for residents and has not cured the delinquency within 10 working days after receipt of notice from the creditor or creditors to pay the debt.

C. The license holder shall notify the Secretary in writing of a significant adverse change in its financial condition as required by §B of this regulation within 72 hours after the license holder becomes aware of, or reasonably should have become aware of, the change in its financial condition.

D. The license holder's notice required by §B of this regulation shall include a description of:

(1) The specific significant adverse change in financial condition;

(2) How the significant adverse change in financial condition affects or may affect the license holder's ability to deliver essential care and services; and

(3) The actions the license holder has taken to address the significant adverse change in financial condition.

E. The license holder shall fax, email, or hand-deliver the notice required in §B of this regulation to the Department's Office of Health Care Quality, and the notice shall be kept on file with a copy of the delivery confirmation.

F. The license holder shall provide any other information, unless prohibited under applicable laws, requested by the Office of Health Care Quality to substantiate continued compliance with the requirements of this regulation within 30 days after the request. Failure to comply with the requirements of this regulation may result in the Secretary imposing one or more sanctions, as appropriate, from Regulations .51—.58 of this chapter against the facility.

G. The information submitted pursuant to §D of this regulation is confidential and may not be disclosed without the consent of the licensee.

H. Unless disclosure of the information is otherwise prohibited by applicable law, the provisions of §G of this regulation do not apply to:

(1) The holder of a license that has been suspended or revoked; or

(2) The use of information in:

(a) An administrative proceeding initiated by the Department; or

(b) A judicial proceeding.

Administrative History

Effective date: June 30, 1978 (5:13 Md. R. 1053)

This chapter is a compilation and revision of prior regulations contained in COMAR 10.07.02, Nursing Homes—Extended Care, and COMAR 10.07.05, Intermediate Care Facilities—Long-term Care (Type A). COMAR 10.07.02 was effective January 1, 1967; amended effective March 27, 1973 and April 16, 1975 (2:8 Md. R. 565). COMAR 10.07.05 was effective July 1, 1969 and amended effective March 27, 1973.

Regulation .01B amended effective January 7, 1991 (17:26 Md. R. 2975); June 22, 1992 (19:12 Md. R. 1134); January 17, 1994 (21:1 Md. R. 33); August 15, 1994 (21:16 Md. R. 1383); June 30, 1997 (24:13 Md. R. 931); June 1, 1998 (25:11 Md. R. 821)

Regulation .01B amended as an emergency provision effective January 1, 2001 (28:4 Md. R. 414); amended permanently effective May 14, 2001 (28:9 Md. R. 885)

Regulation .01B amended effective September 16, 2002 (29:18 Md. R. 1442); March 3, 2003 (30:4 Md. R. 316); September 13, 2004 (31:18 Md. R. 1350)

Regulation .01I-1, L-1, O-1, GG-1 adopted effective January 13, 1986 (13:1 Md. R. 16)

Regulation .01GG-1, KK-1 adopted effective August 3, 1981 (8:15 Md. R. 1306)

Regulation .01II-1 adopted effective January 26, 1987 (14:2 Md. R. 128)

Regulation .01-1 adopted effective June 1, 1998 (25:11 Md. R. 821)

Regulation .01-1 amended effective January 6, 2005 (31:26 Md. R. 1862)

Regulation .02 amended effective January 14, 1988 (15:1 Md. R. 20)

Regulation .02 repealed and new Regulation .02 adopted effective May 10, 1993 (20:9 Md. R. 778)

Regulation .02 amended effective August 24, 2009 (36:17 Md. R. 1312)

Regulation .02F amended effective April 8, 1996 (23:7 Md. R. 551)

Regulation .02G adopted effective September 16, 2002 (29:18 Md. R. 1442)

Regulation .03 amended effective May 10, 1993 (20:9 Md. R. 778); August 27, 2007 (34:17 Md. R. 1507); August 24, 2009 (36:17 Md. R. 1312)

Regulation .03A amended effective May 24, 1982 (9:10 Md. R. 1021); June 22, 1992 (19:12 Md. R. 1134)

Regulation .03B amended effective August 1, 1994 (21:15 Md. R. 1304)

Regulation .03-1 adopted effective May 10, 1993 (20:9 Md. R. 778)

Regulation .04B amended effective December 7, 1992 (19:24 Md. R. 2125)

Regulation .05B amended effective January 17, 1994 (21:1 Md. R. 33)

Regulation .05C amended effective January 25, 1980 (7:2 Md. R. 115)

Regulation .07 amended effective January 26, 1987 (14:2 Md. R. 128); May 20, 1996 (23:10 Md. R. 731); August 24, 2009 (36:17 Md. R. 1312)

Regulation .07A amended effective August 3, 1981 (8:15 Md. R. 1306)

Regulation .07G amended effective May 24, 1982 (9:10 Md. R. 1021); January 26, 1987 (14:2 Md. R. 128); March 3, 2003 (30:4 Md. R. 316)

Regulation .07-1 adopted effective January 1, 2007 (33:26 Md. R. 1996)

Regulation .08 amended effective June 22, 1992 (19:12 Md. R. 1134)

Regulation .08A, B, D amended effective January 26, 1987 (14:2 Md. R. 128)

Regulation .08A, E amended effective January 13, 1986 (13:1 Md. R. 16)

Regulation .08-1 adopted effective September 16, 2002 (29:18 Md. R. 1442)

Regulation .09A amended effective November 8, 1982 (9:22 Md. R. 2196); January 13, 1986 (13:1 Md. R. 16); January 17, 1994 (21:1 Md. R. 33)

Regulation .09B-1 adopted effective August 3, 1981 (8:15 Md. R. 1306)

Regulation .09C, D amended effective August 24, 2009 (36:17 Md. R. 1312)

Regulation .10 amended effective January 26, 1987 (14:2 Md. R. 128); June 30, 1997 (24:13 Md. R. 931)

Regulation .10E amended effective November 8, 1982 (9:22 Md. R. 2196)

Regulation .10H amended effective May 24, 1982 (9:10 Md. R. 1021)

Regulation .10 repealed and new Regulation .10 adopted effective August 6, 2001 (28:15 Md. R. 1396)

Regulation .11 amended effective January 26, 1987 (14:2 Md. R. 128)

Regulation .11O amended effective November 8, 1982 (9:22 Md. R. 2196)

Regulation .11 repealed and new Regulation .11 adopted effective August 6, 2001 (28:15 Md. R. 1396)

Regulation .11-1 adopted effective August 6, 2001 (28:15 Md. R. 1396)

Regulation .11-2 adopted effective August 6, 2001 (28:15 Md. R. 1396)

Regulations .12, .13, .18—.21 amended effective January 13, 1986 (13:1 Md. R. 16)

Regulation .12 amended effective January 26, 1987 (14:2 Md. R. 128)

Regulation .13 amended effective January 26, 1987 (14:2 Md. R. 128)

Regulation .14-1 adopted effective August 15, 1994 (21:16 Md. R. 1383)

Regulation .14-2 adopted effective August 15, 1994 (21:16 Md. R. 1383)

Regulation .15 amended effective January 26, 1987 (14:2 Md. R. 128); September 22, 2008 (35:19 Md. R. 1716)

Regulation .15B amended effective March 16, 1992 (19:5 Md. R. 577); June 5, 1995 (22:11 Md. R. 820)

Regulation .17 amended effective January 26, 1987 (14:2 Md. R. 128)

Regulation .18B amended effective January 26, 1987 (14:2 Md. R. 128)

Regulation .19A, B amended effective January 26, 1987 (14:2 Md. R. 128)

Regulation .20 amended effective January 26, 1987 (14:2 Md. R. 128)

Regulation .21 amended effective June 1, 1998 (25:11 Md. R. 821)

Regulation .21 repealed and new Regulation .21 adopted effective January 6, 2005 (31:26 Md. R. 1862)

Regulation .21E amended effective November 8, 1982 (9:22 Md. R. 2196)

Regulation .21-1 adopted effective January 17, 1994 (21:1 Md. R. 33)

Regulation .21-1 repealed and new Regulation .21-1 adopted effective January 6, 2005 (31:26 Md. R. 1862)

Regulation .21-2 adopted effective January 6, 2005 (31:26 Md. R. 1862)

Regulation .21-3 adopted effective January 6, 2005 (31:26 Md. R. 1862)

Regulation .21-4 adopted effective January 6, 2005 (31:26 Md. R. 1862)

Regulation .22B amended effective August 3, 1981 (8:15 Md. R. 1306)

Regulation .24 repealed and new Regulation .24 adopted effective April 21, 2008 (35:8 Md. R. 805)

Regulation .26F amended and .26G—H repealed effective January 17, 1983 (10:1 Md. R. 28)

Regulation .26EE amended effective October 25, 1982 (9:21 Md. R. 2106); September 16, 2002 (29:18 Md. R. 1442)

Regulation .27A, B amended effective March 3, 2003 (30:4 Md. R. 316)

Regulation .27B amended effective January 26, 1987 (14:2 Md. R. 128)

Regulation .28 amended effective January 26, 1987 (14:2 Md. R. 128); January 17, 1994 (21:1 Md. R. 33)

Regulation .28C amended effective January 14, 1988 (15:1 Md. R. 20)

Regulation .31A amended effective September 16, 2002 (29:18 Md. R. 1442)

Regulation .32F amended effective January 17, 1994 (21:1 Md. R. 33)

Regulation .32G amended effective January 26, 1987 (14:2 Md. R. 128)

Regulation .33E amended effective January 26, 1987 (14:2 Md. R. 128)

Regulations .35—.41 adopted effective January 13, 1986 (13:1 Md. R. 16)

Regulation .35 amended effective December 16, 1996 (23:25 Md. R. 1785)

Regulation .36 amended effective December 16, 1996 (23:25 Md. R. 1785); September 16, 2002 (29:18 Md. R. 1442)

Regulation .36C amended effective March 3, 2003 (30:4 Md. R. 316)

Regulation .37 amended effective December 16, 1996 (23:25 Md. R. 1785); September 16, 2002 (29:18 Md. R. 1442)

Regulation .38 amended effective December 16, 1996 (23:25 Md. R. 1785)

Regulation .39A and B amended effective October 1, 1990 (17:19 Md. R. 2320)

Regulation .39C and D repealed effective October 1, 1990 (17:19 Md. R. 2320)

Regulation .39G amended effective June 30, 1986 (13:13 Md. R. 1491)

Regulation .40A amended effective June 30, 1986 (13:13 Md. R. 1491)

Regulations .40 and .41 recodified to Regulations .43 and .44, respectively, Appendix recodified as Regulation .40 and amended, and new Regulations .41 and .42 adopted effective October 1, 1990 (17:19 Md. R. 2320)

Regulation .41 repealed and new Regulation .41 adopted effective September 13, 2004 (31:18 Md. R. 1350)

Regulation .41A amended effective August 1, 1994 (21:15 Md. R. 1304)

Regulation .41D amended effective June 30, 1986 (13:13 Md. R. 1491)

Regulation .43C adopted effective October 1, 1990 (17:19 Md. R. 2320)

Regulations .45—.51 adopted effective January 7, 1991 (17:26 Md. R. 2975)

Regulations .45—.51 repealed as an emergency provision effective January 1, 2001 (28:4 Md. R. 414); repealed permanently effective May 14, 2001 (28:9 Md. R. 885)

Regulations .45—.60 adopted as an emergency provision effective January 1, 2001 (28:4 Md. R. 414); adopted permanently effective May 14, 2001 (28:9 Md. R. 885)

Regulation .49D amended effective September 16, 2002 (29:18 Md. R. 1442)

Regulation .54D adopted effective March 3, 2003 (30:4 Md. R. 316)

Regulation .61 adopted effective August 24, 2009 (36:17 Md. R. 1312)