

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

**CHAPTER 1200-08-11
STANDARDS FOR HOMES FOR THE AGED**

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1200-08-11-.01 DEFINITIONS.

- (1) Abuse. The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.
- (2) Activities of Daily Living (ADL's). Those personal functional activities which indicate an individual's independence in eating, dressing, personal hygiene, bathing, toileting, and moving from one place to another.
- (3) Adult. An individual who has capacity and is at least 18 years of age.
- (4) Advance Directive. An individual instruction or a written statement relating to the subsequent provision of health care for the individual, including, but not limited to, a living will or a durable power of attorney for health care.
- (5) Aged. A person who is fifty-five (55) years of age or older.
- (6) Agent. An individual designated in an advance directive for health care to make a health care decision for the individual granting the power.
- (7) Ambulatory resident. A resident who is physically and mentally capable under emergency conditions of finding a way to safety without physical assistance from another person. An ambulatory resident may use a cane, wheelchair or other supportive device and may require verbal prompting.
- (8) Board. The Tennessee Board for Licensing Health Care Facilities.
- (9) Capacity. An individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision. These regulations do not affect the right of a resident to make health care decisions while having the capacity to do so. A resident shall be presumed to have capacity to make a health care decision, to give or revoke an advance directive, and to designate or disqualify a surrogate. Any person who challenges the capacity of a resident shall have the burden of proving lack of capacity.
- (10) Cardiopulmonary Resuscitation (CPR). The administering of any means or device to restore or support cardiopulmonary function in a resident, whether by mechanical devices, chest compressions, mouth-to-mouth resuscitation, cardiac massage, tracheal intubation, manual

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or mechanical ventilators or respirations, defibrillation, the administration of drugs and/or chemical agents intended to restore cardiac and/or respiratory functions in a resident where cardiac or respiratory arrest has occurred or is believed to be imminent.

- (11) Commissioner. The Commissioner of the Tennessee Department of Health or his or her authorized representative.
- (12) Department. The Tennessee Department of Health.
- (13) Designated Physician. A physician designated by an individual or the individual's agent, guardian, or surrogate, to have primary responsibility for the individual's health care or, in the absence of designation or if the designated physician is not reasonably available, a physician who undertakes such responsibility.
- (14) Do-Not-Resuscitate Order (DNR). A written order, other than a POST, not to resuscitate a patient in cardiac or respiratory arrest in accordance with accepted medical practices.
- (15) Emancipated Minor. Any minor who is or has been married or has by court order or otherwise been freed from the care, custody and control of the minor's parents.
- (16) Emergency. Any situation or condition which presents an imminent danger of death or serious physical or mental harm to residents.
- (17) Emergency responder. A paid or volunteer firefighter, law enforcement officer, or other public safety official or volunteer acting within the scope of his or her proper function under law or rendering emergency care at the scene of an emergency.
- (18) Evacuation Capability. The ability to either evacuate the building or move to a point of safety.
- (19) Guardian. A judicially appointed guardian of conservator having authority to make a health care decision
- (20) Hazardous Waste. Materials whose handling, use, storage, and disposal are governed by local, state, or federal regulations.
- (21) Health Care. Any care, treatment, service or procedure to maintain, diagnose, treat, or otherwise affect an individual's physical or mental condition, and includes medical care as defined in T.C.A. § 32-11-103(5)
- (22) Health care decision. Consent, refusal or consent or withdrawal of consent to health care.
- (23) Health Care Decision-maker. In the case of a resident who lacks capacity, the resident's health care decision-maker is one of the following: the resident's health care agent as specified in an advance directive, the resident's court-appointed guardian or conservator with healthcare decision-making authority, the resident's surrogate as determined pursuant to Rule 1200-08-11-.12 or T.C.A. § 33-3-220, the designated physician pursuant to these Rules or in the case of a minor child, the person having custody or legal guardianship.
- (24) Health Care Institution. A health care institution as defined in T.C.A. § 68-11-1602.
- (25) Health Care Provider. A person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care in the ordinary course of business or practice of a profession.

(Rule 1200-08-11-.01, continued)

- (26) Holding Out to the Public. Advertising or soliciting the public through the use of personal, telephone, mail or other forms of communication to provide information about services provided by the facility.
- (27) Home for the Aged. A home represented and held out to the general public as a home which accepts primarily aged persons for relatively permanent, domiciliary care with primarily being defined as 51% or more of the population of the home for the aged. It provides room, board and personal services to four (4) or more nonrelated persons. The term home includes any building or part thereof which provides services as defined in these rules.
- (28) Home for the Aged Resident. A person who is ambulatory and who requires permanent, domiciliary care but who will be transferred to a licensed hospital, licensed nursing home or licensed assisted care living facility when health care services are needed which must be provided in such other facilities.
- (29) Incompetent. A resident who has been adjudicated incompetent by a court of competent jurisdiction and has not been restored to legal capacity.
- (28) Individual instruction. An individual's direction concerning a health care decision for the individual.
- (30) Infectious Waste. Solid or liquid wastes which contain pathogens with sufficient virulence and quantity such that exposure to the waste by a susceptible host could result in an infectious disease.
- (31) Licensee. The person or entity to whom the license is issued. The licensee is held responsible for compliance with all rules and regulations.
- (32) Life Threatening Or Serious Injury. Injury requiring the patient to undergo significant additional diagnostic or treatment measures.
- (33) Medically Inappropriate Treatment. Resuscitation efforts that cannot be expected either to restore cardiac or respiratory function to the resident or other medical or surgical treatments to achieve the expressed goals of the informed resident. In the case of the incompetent resident, the resident's representative expresses the goals of the resident
- (34) N.F.P.A. The National Fire Protection Association.
- (35) Misappropriation of Patient/Resident Property. The deliberate misplacement, exploitation or wrongful, temporary or permanent use of an individual's belongings or money without the individual's consent.
- (36) Neglect. The failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness; however, the withholding of authorization for or provision of medical care to any terminally ill person who has executed an irrevocable living will in accordance with the Tennessee Right to Natural Death Law, or other applicable state law, if the provision of such medical care would conflict with the terms of the living will, shall not be deemed "neglect" for purposes of these rules.
- (37) Person. An individual, corporation, estate, trust, partnership, association, joint venture, government, governmental subdivision, agency or instrumentality, or any other legal or commercial entity.
- (38) Personal Services. Those services that are rendered to residents who need supervision or assistance in activities of daily living. Personal services must include protective care of the resident, responsibility for the safety of the resident when in the facility, daily awareness of

(Rule 1200-08-11-.01, continued)

the resident's whereabouts and the ability and readiness to intervene if crises arise. Personal services do not include nursing or medical care.

- (39) Personally Informing. A communication by any effective means from the resident directly to a health care provider.
- (40) Physician Assistant. A person who has graduated from a physician assistant educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant, has passed the Physician Assistant National Certifying Examination, and is currently licensed in Tennessee as a physician assistant under Title 63, Chapter 19.
- (41) Physician Orders for Scope of Treatment or POST. Written orders that:
- (a) Are on a form approved by the Board for Licensing Health Care Facilities;
 - (b) Apply regardless of the treatment setting and that are signed as required herein by the patient's physician, physician assistant, nurse practitioner, or clinical nurse specialist; and
 - (c)
 - 1. Specify whether, in the event the patient suffers cardiac or respiratory arrest, cardiopulmonary resuscitation should or should not be attempted;
 - 2. Specify other medical interventions that are to be provided or withheld; or
 - 3. Specify both 1 and 2.
- (42) Power of Attorney for Health Care. The designation of an agent to make health care decisions for the individual granting the power under T.C.A. Title 34, Chapter 6, Part 2.
- (43) Qualified Emergency Medical Service Personnel. Includes, but shall not be limited to, emergency services personnel providers, or entities acting within the usual course of their professions, and other emergency responders.
- (44) Reasonably Available. Readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the resident's health care needs. Such availability shall include, but not limited to, availability by telephone.
- (45) Responsible Attendant. The person designated by the licensee who remains awake to provide personal services to the residents. In the absence of the licensee, the responsible attendant is responsible for ensuring the home complies with all rules and regulations.
- (46) Secured Unit. A facility or distinct part of a facility where the residents are intentionally denied egress by any means.
- (47) Shall or Must. Compliance is mandatory.
- (48) State. A state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.
- (49) Supervising Health Care Provider. The designated physician or, if there is no designated physician or the designated physician is not reasonably available, the health care provider who has undertaken primary responsibility for an individual's health care.

(Rule 1200-08-11-.01, continued)

- (50) Surrogate. An individual, other than a resident's agent or guardian, authorized to make a health care decision for the resident.
- (51) Treating Health Care Provider. A health care provider who at the time is directly or indirectly involved in providing health care to the resident.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 39-11-106, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, 68-11-213, 68-11-216, 68-11-224, and 68-11-1802.

Administrative History: Original rule filed June 21, 1979; effective August 6, 1979. Amendment filed August 16, 1988; effective September 30, 1988. Amendment filed January 30, 1992; effective March 15, 1992. Amendment filed December 7, 1993; effective February 20, 1994. Repeal and new rule filed July 27, 2000; effective October 10, 2000. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed April 28, 2003; effective July 12, 2003. Amendment filed September 8, 2006; effective November 22, 2006. Amendment filed February 7, 2007; effective April 23, 2007. Amendment filed February 23, 2007; effective May 9, 2007. Amendment filed January 3, 2012; effective April 2, 2012. Amendment filed March 27, 2015; effective June 25, 2015. Amendments filed July 10, 2018; effective October 8, 2018.

1200-08-11-.02 LICENSING PROCEDURES.

- (1) No person, partnership, association, corporation, or state, county or local government unit, or any division, department, board or agency thereof, shall establish, conduct, operate, or maintain in the State of Tennessee any home for the aged without having a license. A license shall be issued only to the applicant named and only for the premises listed in the application for licensure. Licenses are not transferable or assignable and shall expire and become invalid annually on the anniversary date of their original issuance. The license shall be conspicuously posted in the home for the aged.
- (2) In order to make application for a license:
 - (a) The applicant shall submit an application on a form prepared by the department.
 - (b) Each applicant for a license shall pay an annual license fee based on the number of beds as follows:

1. Less than 6 beds	\$ 390.00
2. 6 to 24 beds, inclusive	\$ 1,040.00
3. 25 to 49 beds, inclusive	\$ 1,300.00
4. 50 to 74 beds, inclusive	\$ 1,560.00
5. 75 to 99 beds, inclusive	\$ 1,820.00
6. 100 to 124 beds, inclusive	\$ 2,080.00
7. 125 to 149 beds, inclusive	\$ 2,340.00
8. 150 to 174 beds, inclusive	\$ 2,600.00
9. 175 to 199 beds, inclusive	\$ 2,860.00

For homes for the aged of two hundred (200) beds or more the fee shall be two thousand eight hundred and sixty dollars (\$2,860.00) plus two hundred dollars (\$200.00) for each twenty-five (25) beds or fraction thereof in excess of one hundred

(Rule 1200-08-11-.02, continued)

ninety-nine (199) beds. The fee shall be submitted with the application or renewal and is not refundable.

- (c) The issuance of an application form is in no way a guarantee that the completed application will be accepted or that a license will be issued by the department. Residents shall not be admitted to the home until a license has been issued. Applicants shall not hold themselves out to the public as being a home for the aged until the license has been issued. A license shall not be issued until the facility is in substantial compliance with these rules.
 - (d) The applicant must prove the ability to meet the financial needs of the facility.
 - (e) The applicant shall not use subterfuge or other evasive means to obtain a license, such as filing for a license through a second party when an individual has been denied a license or has had a license disciplined or has attempted to avoid inspection and review process.
 - (f) The applicant shall allow the residential home for the aged to be inspected by a Department surveyor. In the event that deficiencies are noted, the applicant shall submit a plan of corrective action to the Board that must be accepted by the Board. Once the deficiencies have been corrected, then the Board shall consider the application for licensure.
- (3) A proposed change of ownership, including a change in a controlling interest, must be reported to the department a minimum of thirty (30) days prior to the change. A new application and fee must be received by the department before the license may be issued.
- (a) For the purpose of licensing, the licensee of a home for the aged has the ultimate responsibility for the operation of the facility, including the final authority to make or control operational decisions and legal responsibility for the business management. A change of ownership occurs whenever this ultimate legal authority for the responsibility of the home's operation is transferred.
 - (b) A change of ownership occurs whenever there is a change in the legal structure by which the home is owned and operated.
 - (c) Transactions constituting a change of ownership include, but are not limited to, the following:
 - 1. Transfer of the facility's legal title;
 - 2. Lease of the facility's operations;
 - 3. Dissolution of any partnership that owns, or owns a controlling interest in, the facility;
 - 4. One partnership is replaced by another through the removal, addition or substitution of a partner;
 - 5. Removal of the general partner or general partners, if the facility is owned by a limited partnership;
 - 6. Merger of a facility owner (a corporation) into another corporation where, after the merger, the owner's shares of capital stock are canceled;
 - 7. The consolidation of a corporate facility owner with one or more corporations; or

(Rule 1200-08-11-.02, continued)

8. Transfers between levels of government.
- (d) Transactions which do not constitute a change of ownership include, but are not limited to, the following:
 1. Changes in the membership of a corporate board of directors or board of trustees;
 2. Two (2) or more corporations merge and the originally-licensed corporation survives;
 3. Changes in the membership of a non-profit corporation;
 4. Transfers between departments of the same level of government; or
 5. Corporate stock transfers or sales, even when a controlling interest.
 - (e) Management agreements are generally not changes of ownership if the owner continues to retain ultimate authority for the operation of the facility. However, if the ultimate authority is surrendered and transferred from the owner to a new manager, then a change of ownership has occurred.
 - (f) Sale/lease-back agreements shall not be treated as changes in ownership if the lease involves the facility's entire real and personal property and if the identity of the leasee, who shall continue the operation, retains the exact same legal form as the former owner.
- (4) Renewal.
 - (a) In order to renew a license, each residential home for the aged shall submit to periodic inspections by Department surveyors for compliance with these rules. If deficiencies are noted, the licensee shall submit an acceptable plan of corrective action and shall remedy the deficiencies. In addition, each licensee shall submit a renewal form approved by the board and applicable renewal fee prior to the expiration date of the license.
 - (b) If a licensee fails to renew its license prior to the date of its expiration but submits the renewal form and fee within sixty (60) days thereafter, the licensee may renew late by paying, in addition to the renewal fee, a late penalty of one hundred dollars (\$100) per month for each month or fraction of a month that renewal is late; provided that the late penalty shall not exceed twice the renewal fee.
 - (c) In the event that a licensee fails to renew its license within the sixty (60) day grace period following the license expiration date, then the licensee shall reapply for a license by submitting the following to the Board office:
 1. A completed application for licensure; and
 2. The license fee provided in rule 1200-08-11-.02(2)(b).
 - (d) Upon reapplication, the licensee shall submit to an inspection of the facility by Department of Health surveyors.
 - (5) A license shall be issued only for the location designated and the licensee named in the application. If a home moves to a new location, a new license will be required before

(Rule 1200-08-11-.02, continued)

residents are admitted. A licensee who plans to relocate must contact the department to inspect the new building prior to relocation.

- (6) Any admission in excess of the licensed bed capacity is prohibited.
- (7) A separate license shall be required for each home for the aged when more than one home is operated under the same management or ownership.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-209(a)(1), 68-11-210, 68-11-216, Chapter 846 of the Public Acts of 2008, § 1, and T.C.A. § 68-11-206(a)(5) [effective January 1, 2009]. **Administrative History:** Original rule filed June 21, 1979; effective August 6, 1997. Amendment filed August 16, 1988; effective September 30, 1988. Amendment filed January 30, 1992; effective March 15, 1992. Repeal and new rule filed July 27, 2000; effective October 10, 2000. Amendment filed November 19, 2003; effective February 2, 2004. Amendment filed September 8, 2006; effective November 22, 2006. Amendment filed January 19, 2007; effective April 4, 2007. Public necessity rules filed April 29, 2009; effective through October 11, 2009. Emergency rules filed October 9, 2009; effective through April 7, 2010. Amendments filed September 24, 2009; effective December 23, 2009. Amendment filed December 16, 2013; effective March 16, 2014. Amendments filed March 21, 2018; to have been effective June 19, 2018. However, on May 24, 2018, the Government Operations Committee filed a 5-day stay; new effective date June 24, 2018.

1200-08-11-.03 DISCIPLINARY PROCEDURES.

- (1) The board may suspend or revoke a license for:
 - (a) Violation of state statutes;
 - (b) Violation of the rules as set forth in this chapter;
 - (c) Permitting, aiding or abetting the commission of any illegal act in the home;
 - (d) Conduct or practice found by the board to be detrimental to the health, safety, or welfare of the residents of the home; and
 - (e) Failure to renew the license.
- (2) The board may consider all factors which it deems relevant, including but not limited to the following, when determining sanctions:
 - (a) The degree of sanctions necessary to ensure immediate and continued compliance;
 - (b) The character and degree of impact of the violation on the health, safety and welfare of the residents in the home;
 - (c) The conduct of the home in taking all feasible steps or procedures necessary or appropriate to comply or correct the violation; and
 - (d) Any prior violations by the home of statutes, rules or orders of the Commissioner or the board.
- (3) Failure to timely submit an acceptable plan of correction shall subject the home's license to possible disciplinary action.
- (4) The Commissioner may suspend the admission of any new residents to the home, pending a prompt hearing before the board or an administrative law judge, when the conditions are or are likely to be detrimental to the health, safety or welfare of the residents.

(Rule 1200-08-11-.03, continued)

- (5) Whenever the Commissioner suspends the admission of any new residents to the home because of the detrimental conditions found, the home shall post a copy of the Commissioner's Order upon the public entrance doors of the facility and prominently display it there for so long as it remains effective and until the Commissioner or the board removes the suspension and restores the facility's ability to admit new residents. During the suspension, the home shall inform any person who inquires about the admission of a new resident of the provisions of the order and make a copy of the order available for the inquirer's inspection.
- (6) Following a contested case hearing, the board may find a facility's license subject to suspension or revocation and may then immediately impose any sanction authorized by law.
- (7) The board may recommend the appointment of one or more special monitors to serve such term and to be present in the home for such hours each week as the board finds necessary and appropriate, as specified in its order. The home shall reimburse the reasonable fees and expenses of any special monitor so appointed by the board.
- (8) Any licensee or applicant for a license, aggrieved by a decision or action of the department or board, pursuant to this rule, may request a hearing before the board. The proceedings and judicial review of the board's decision shall be in accordance with the Uniform Procedures Act, T.C.A. §§ 4-5-101, et seq.
- (9) Reconsideration and Stays. The Board authorizes the member who chaired the Board for a contested case to be the agency member to make the decisions authorized pursuant to rule 1360-04-01-.18 regarding petitions for reconsiderations and stays in that case.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 4-5-219, 4-5-312, 4-5-316, 4-5-317, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-208, 68-11-209, and 68-11-221. **Administrative History:** Original rule filed June 21, 1979; effective August 6, 1979. Amendment filed August 16, 1988; effective September 30, 1988. Repeal and new rule filed July 27, 2000; effective October 10, 2000. Amendment filed March 1, 2007; effective May 15, 2007.

1200-08-11-.04 ADMINISTRATION.

- (1) The licensee shall be at least eighteen (18) years of age, of reputable and responsible character, able to comply with these rules, and must maintain financial resources and income sufficient to provide for the needs of the residents, including their room, board and personal services.
- (2) The licensee must designate in writing a capable and responsible person to act on administrative matters and to exercise all the powers and responsibilities of the licensee as set forth in this chapter in the absence of the licensee.
- (3) Each home must have an administrator who shall be certified by the board, unless the administrator is currently licensed in Tennessee as a nursing home administrator pursuant to T.C.A. §§ 63-16-101, et seq.
- (4) An applicant for certification as a home for the aged administrator shall meet the following requirements:
 - (a) Must be at least eighteen (18) years of age and a high school graduate or the holder of a general equivalency diploma.
 - (b) Must not have been convicted of a criminal offense involving the abuse or intentional neglect of an elderly or vulnerable individual.

(Rule 1200-08-11-.04, continued)

- (c) Must submit an application, on a form provided by the department, and a fee of one hundred eighty dollars (\$180) prior to issuance or renewal of a certificate. All certificates shall expire biennially on June 30, thereafter.
- (d) Biennial renewal of certification is required. The renewal application and fee of one hundred eighty dollars (\$180) shall be submitted with written proof of attendance, during the period prior to renewal, of at least twenty-four (24) classroom hours of continuing education courses. The initial biennial re-certification expiration date of Home for the Aged administrator candidates who receive their initial administrator certification between the dates of January 1 and June 30 of any year will be extended to two (2) years plus the additional months remaining in the fiscal year. The extension applies only to the first biennial certification period for any such administrator and may only be applied when there are less than six (6) months remaining in the State fiscal year.
- (e) Continuing education.
 - 1. The twenty-four (24) classroom hours of required continuing education courses shall include instruction in the following:
 - (i) State rules and regulations for homes for the aged;
 - (ii) Health care management;
 - (iii) Nutrition and food service;
 - (iv) Financial management; and
 - (v) Healthy lifestyles.
 - 2. All educational courses must be approved by the board. Courses sponsored by the National Association of Residential Care Facilities and the National Association of Nursing Home Administrators are deemed approved by the board.
 - 3. In order to obtain board approval for educational courses, a copy of the course curriculum must be submitted to the board for approval prior to attending the course.
 - 4. Proof of administrator certification course attendance shall be submitted to the department upon completion of the course.
- (5) Infection Control. A Home for the Aged shall have an annual influenza vaccination program which shall include at least:
 - (a) The offer of influenza vaccination to all staff and independent practitioners at no cost to the person or acceptance of documented evidence of vaccination from another vaccine source or facility. The Home for the Aged will encourage all staff and independent practitioners to obtain an influenza vaccination;
 - (b) A signed declination statement on record from all who refuse the influenza vaccination for reasons other than medical contraindications (a sample form is available at <https://www.tn.gov/content/dam/tn/health/documents/SampleIndividualFluForm.pdf>);
 - (c) Education of all employees about the following:

(Rule 1200-08-11-.04, continued)

1. Flu vaccination,
 2. Non-vaccine control measures, and
 3. The diagnosis, transmission, and potential impact of influenza;
- (d) An annual evaluation of the influenza vaccination program and reasons for non-participation; and
- (e) A statement that the requirements to complete vaccinations or declination statements shall be suspended by the administrator in the event of a vaccine shortage as declared by the Commissioner or the Commissioner's designee.
- (6) Each home for the aged shall:
- (a) Have an identified responsible attendant and a sufficient number of employees to meet the needs of the residents. The responsible attendant must be at least eighteen (18) years of age and able to comply with these rules.
 - (b) Have a responsible awake attendant on the premises at all times.
 - (c) Maintain documentation of the checks of the "Registry of Persons who have Abused or Intentionally Neglected Elderly or Vulnerable Individuals" prior to hiring any employee.
 - (d) Have a written statement of policies and procedures outlining the responsibilities of the licensee to the resident and any obligation of the resident to the facility.
 - (e) Post whether they have liability insurance, the identity of their primary insurance carrier, and if self-insured, the corporate entity responsible for payment of any claims. It shall be posted on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height and displayed at the main public entrance.
 - (f) Keep a written up-to-date log of all residents and produce the log for the local fire department in the event of an emergency.
 - (g) Maintain written policies and procedures informing the resident of his/her rights and how to register grievances and complaints.
 - (h) Not allow an owner, responsible attendant, employee or representative thereof to act as a court-appointed guardian, trustee, or conservator for any resident of the facility or any of such resident's property or funds, except as provided by rule 1200-08-11-.10.
 - (i) Cooperate in the Department's inspections including allowing entry at any hour and providing all required records.
 - (j) Develop and follow a written policy, plan, procedure, technique or system regarding a subject whenever these rules require that a licensee develop such a plan. A residential home which violates a required policy also violates the rule establishing the requirements.
 - (k) Not retaliate against or, in any manner, discriminate against any person because of a complaint made in good faith and without malice to the board, the department, Adult Protective Services, the Comptroller of the State Treasury or the Long Term Care Ombudsman Program. A home shall neither retaliate nor discriminate because of information lawfully provided to these authorities, because of a person's cooperation

(Rule 1200-08-11-.04, continued)

with them or because a person is subpoenaed to testify at a hearing involving one of these authorities.

- (l) Allow pets in the home only when they are not a nuisance or do not pose a health hazard.
 - (m) Comply with all local laws, rules or ordinances, and with this chapter.
 - (n) The facility shall develop a concise statement of its charity care policies and shall post such statement in a place accessible to the public.
- (7) No occupant or employee who has a reportable communicable disease, as stipulated by the department, is permitted to reside or work in a home unless the home has a written protocol approved by the department.
- (8) All health care facilities licensed pursuant to T.C.A. §§ 68-11-201, et seq. shall post the following in the main public entrance:
- (a) Contact information including statewide toll-free number of the division of adult protective services, and the number for the local district attorney's office;
 - (b) A statement that a person of advanced age who may be the victim of abuse, neglect, or exploitation may seek assistance or file a complaint with the division concerning abuse, neglect and exploitation; and
 - (c) A statement that any person, regardless of age, who may be the victim of domestic violence may call the nationwide domestic violence hotline, with that number printed in boldface type, for immediate assistance and posted on a sign no smaller than eight and one-half inches (8½") in width and eleven inches (11") in height.

Postings of (a) and (b) shall be on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height.

- (9) "No Smoking" signs or the international "No Smoking" symbol, consisting of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it, shall be clearly and conspicuously posted at every entrance.
- (10) Residents of the facility are exempt from the smoking prohibition. The resident smoking practices shall be governed by the policies and procedures established by the facility. Smoke from such areas shall not infiltrate into areas where smoking is prohibited.
- (11) Mandatory Testing for COVID-19.
- (a) The requirements of this paragraph apply to all homes for the aged licensed under Title 68, Chapter 11.
 - (b) Homes for the aged shall comply with all Department of Health infection and prevention directives concerning staff and resident testing, including making off-shift staff available at the facility for testing.
 - (c) "Staff" or "Staff member" for the purposes of this paragraph shall mean an employee or any individual who contracts with the facility to provide resident care.
 - (d) Initial Statewide Testing:

(Rule 1200-08-11-.04, continued)

1. Each home for the aged must complete an “intent to test” survey as provided for by the Department prior to June 1, 2020.
 2. Each home for the aged resident and staff member must be tested by June 30, 2020.
 3. Initial statewide testing may be done at the State Public Health Lab (SPHL), commercial labs with whom the State has agreements or through commercial laboratories with whom the facility has agreements. The facility may use any commercial labs using a test with U.S. Food and Drug Administration (FDA) emergency use authorization and which will report results as required by law.
 4. The Department shall assist any home for the aged without nursing staff in securing the licensed personnel necessary to take resident and staff samples, but facility support will be required for administrative tasks.
 5. A home for the aged may use a commercial lab without the prior consent of the Department.
 6. Within one (1) day of the effective date of this rule, the Department shall publish a list of previously approved labs.
 7. The Department will provide sufficient personal protective equipment for the initial statewide testing described in this paragraph.
- (e) Residents and staff have the right to refuse testing. Each facility shall document the staff or resident’s refusal by having the individual sign documentation created by the facility indicating that they have refused testing.
- (f) A violation of this paragraph is considered to be a serious deficiency. For a violation of any part of this paragraph, the Department may seek any remedy authorized by Tenn. Code Ann. §§ 68-11-207 and 68-11-213, including but not limited to, license revocation, license suspension, and the imposition of civil monetary penalties.
- (g) It shall be a defense to any disciplinary action taken under this paragraph that a facility is unable to identify a COVID-19 testing laboratory, or that total statewide testing capacity is insufficient to accommodate the anticipated number of tests required by these rules.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 39-17-1803, 39-17-1804, 39-17-1805, 68-11-201, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-213, 68-11-257, 68-11-268, and 71-6-121.

Administrative History: Original rule filed June 21, 1997; effective August 6, 1979. Amendment filed August 16, 1988; effective September 30, 1988. Repeal and new rule filed July 27, 2000; effective October 10, 2000. Amendment filed April 20, 2006; effective July 4, 2006. Amendment filed February 23, 2007; effective May 9, 2007. Amendment filed July 18, 2007; effective October 1, 2007. Amendment filed February 22, 2010; effective May 23, 2010. Amendments filed July 18, 2016; effective October 16, 2016. Administrative correction made to URL on September 18, 2018. Emergency rules filed May 29, 2020; effective through November 25, 2020.

1200-08-11-.05 ADMISSIONS, DISCHARGES AND TRANSFERS.

- (1) Only residents whose needs can be met by the facility within its licensure category shall be admitted.
- (2) Prior to the admission of a resident or prior to the execution of a contract for the care of a resident (whichever occurs first), each home for the aged shall disclose in writing to the

(Rule 1200-08-11-.05, continued)

resident or to the resident's guardian, conservator or representative, if any, whether the facility has liability insurance and the identity of the primary insurance carrier. If the facility is self-insured, their statement shall reflect that fact and indicate the corporate entity responsible for payment of any claims.

- (3) The home shall:
- (a) Be able to identify at the time of admission and during continued stay those residents whose needs for services are consistent with these rules and those residents who should be transferred to a higher level of care.
 - (b) Have a written admission agreement that includes a procedure for handling the transfer or discharge of residents and that does not violate the residents' rights under the law or these rules.
 - (c) Have an accurate written statement regarding fees and services which will be provided upon admission.
 - (d) Give a thirty (30) day notice to all residents before any changes in fees can be made.
 - (e) Ensure that residents see a physician for acute illness or injury and are transferred in accordance with any physician's orders.
 - (f) The Facility shall document evidence of annual vaccination against influenza for each resident, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control most recent to the time of vaccine, unless such vaccination is medically contraindicated or the resident has refused the vaccine. Influenza vaccination for all residents accepting the vaccine shall be completed by November 30 of each year or within ten (10) days of the vaccine becoming available. Residents admitted after this date during the flu season and up to February 1, shall as medically appropriate, receive influenza vaccination prior to or on admission unless refused by the resident.

The facility shall document evidence of vaccination against pneumococcal disease for all residents who are sixty five (65) years of age or older, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control at the time of vaccination, unless such vaccination is medically contraindicated or the resident has refused offer of the vaccine. The facility shall provide or arrange the pneumococcal vaccination of residents who have not received this immunization prior to or on admission unless the resident refuses offer of the vaccine.
 - (g) Provide to the resident at the time of admission a copy of the Resident's Rights for the resident's review and signature. A signed copy must be provided to the resident at the time of admission.
- (4) Individuals who require professional medical or nursing observation and/or care on a continual or daily basis shall not be admitted to or retained in the home, with the following exception: When an individual who resides in the facility develops a temporary illness, injury, or disability requiring short-term medical or nursing care, the individual may remain in the home if such care can be safely and appropriately given in that setting and is provided by licensed professionals.
- (5) Individuals who are usually, typically or customarily incapable of self-administering medications or who require medications that are usually, typically or customarily not self-

(Rule 1200-08-11-.05, continued)

administered shall not be admitted to or retained in the home unless provided by a home care organization or physician.

- (6) Residents who require professional medical or nursing observation and/or care on a continual or daily basis or who require more technical medical or nursing care than the personnel and the home can lawfully offer on a short-term basis as described in paragraph (3), shall be transferred to a licensed hospital, nursing home or assisted care living facility.
- (7) A home for the aged shall not admit or retain residents who pose a clearly documented danger to themselves or to other residents in the home. Persons in the early stages of Alzheimer's Disease and Related Disorders may be admitted only after it has been determined by an interdisciplinary team that care can appropriately and safely be given in the facility. The interdisciplinary team must review such persons at least quarterly as to the appropriateness of placement in the facility. The interdisciplinary team shall consist of, at a minimum, a physician experienced in the treatment of Alzheimer's Disease and Related Disorders, a social worker, a registered nurse, and a family member (or patient care advocate).
- (8) Residents shall be capable of evacuating the home in accordance with Chapter 22 of the Life Safety Code. Residents who cannot evacuate within thirteen (13) minutes shall not be admitted or retained in the facility.
- (9) The licensee shall not admit or retain a resident who requires physical or chemical restraint.
- (10) Facilities utilizing secured units must be able to annually provide survey staff with twelve (12) months of the following performance information specific to the secured unit and its residents:
 - (a) Documentation that each secured resident has been evaluated by the interdisciplinary team prior to admittance to the unit;
 - (b) Ongoing and up-to-date documentation of quarterly review by each resident's interdisciplinary team as to the appropriateness of placement in the secured unit;
 - (c) A current listing of the number of deaths and hospitalizations with diagnoses that have occurred on the unit;
 - (d) A current listing of all unusual incidents and/or complications on the unit;
 - (e) An up-to-date staffing pattern and staff ratios for the unit recorded on a daily basis. The staffing pattern must ensure that there is a minimum of one (1) attendant, awake, on duty and physically located on the unit twenty-four (24) hours per day, seven (7) days per week at all times;
 - (f) A formulated calendar of daily group activities scheduled including a resident attendance record for the previous three (3) months;
 - (g) An up-to-date listing of any incidences of decubitus and/or nosocomial infections, including resident identifiers; and
 - (h) Documentation showing that 100% of the staff working on the unit receives and has received annual in-service training which shall include but not be limited to the following subject areas:
 1. Basic facts about the causes, progression and management of Alzheimer's Disease and related disorders;

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2. Dealing with dysfunctional behavior and catastrophic reactions in the residents;
 3. Identifying and alleviating safety risks to the residents;
 4. Providing assistance in the activities of daily living for the residents; and
 5. Communicating with families and other persons interested in the residents.
- (11) The facility shall ensure that no person on the grounds of race, color, national origin, or handicap, will be excluded from participation in, be denied benefits of, or otherwise subjected to discrimination in the provision of any care or service of the facility. The facility shall protect the civil rights of residents under the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.
- (12) Any residential facility licensed by the board of licensing health care facilities shall upon admission provide to each resident the division of adult protective services' statewide toll-free number: 888-277-8366.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-210, 68-11-257, and 71-6-121. **Administrative History:** Original rule filed June 21, 1979; effective August 6, 1997. Amendment filed August 16, 1988; effective September 30, 1988. Repeal and new rule filed July 27, 2000; effective October 10, 2000. Amendment filed April 20, 2006; effective July 4, 2006. Amendment filed February 23, 2007; effective May 9, 2007.

1200-08-11-.06 PERSONAL SERVICES.

- (1) Personal services must include protective care of the resident, responsibility for the safety of the resident when in the facility, daily awareness of the resident's whereabouts and the ability and readiness to intervene if crises arise. Personal services do not include nursing or medical care. Personal services must be provided by employees of the home.
- (2) Medications shall be self-administered. If the home chooses to employ a currently licensed nurse, medications may be administered by the nurse.
- (3) Assistance in reading labels, opening bottles, reminding residents of their medication, observing the resident while taking medication and checking the self-administered dose against the dosage shown on the prescription are permissible in the self-administration of medications.
- (4) All medications shall be stored so that no resident can obtain another resident's medication.
- (5) Residents shall be provided assistance, if needed, in personal care such as bathing, grooming and dressing.
- (6) The home for the aged shall provide laundry arrangements for linens for the home and for residents' clothing.
- (7) Appropriate storage areas for soiled linen and residents' clothing shall be provided.
- (8) Clean linen shall be maintained in sufficient quantity to provide for the needs of the residents. Linens shall be changed whenever necessary.
- (9) There must be a designated person responsible for the food service, including the purchasing of adequate food supplies and the maintenance of sanitary practices in food storage, preparation and distribution. Sufficient arrangements or employees shall be maintained to cook and serve the food.

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- (10) Residents shall be provided at least three (3) meals per day. The meals shall constitute an acceptable diet. There shall be no more than fourteen (14) hours between the evening and morning meals. All food served to the residents shall be of good quality and variety, sufficient quantity, attractive and at safe temperatures. Prepared foods shall be kept hot (140°F or above) or cold (41°F or less). The food must be adapted to the habits, preferences, needs and physical abilities of the residents.
- (11) Sufficient food provision capabilities and dining space shall be provided.
- (12) A forty-eight (48) hour supply of food shall be maintained and properly stored at all times.
- (13) Appropriate equipment and utensils for cooking and serving food shall be provided in sufficient quantity to serve all residents and must be in good repair.
- (14) The kitchen shall be maintained in a clean and sanitary condition.
- (15) Equipment, utensils and dishes shall be washed after each use.
- (16) A suitable and comfortable furnished area shall be provided in the facility for activities and family visits. Furnishings shall include a current calendar and a functioning television set, radio and clock.
- (17) The facility shall provide current newspapers, magazines or other reading materials.
- (18) The home must have a telephone accessible to all residents to make and receive personal telephone calls twenty-four (24) hours per day.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, and 68-11-204. **Administrative History:** Original rule filed June 21, 1979; effective August 6, 1979. Amendment filed August 16, 1988; effective September 30, 1988. Repeal and new rule filed July 27, 2000; effective October 10, 2000.

1200-08-11-.07 BUILDING STANDARDS.

- (1) An RHA shall construct, arrange, and maintain the condition of the physical plant and the overall RHA environment in such a manner that the safety and well-being of the patients are assured.
- (2) After the applicant has submitted an application and licensure fees, the applicant must submit the building construction plans to the department. All facilities shall conform to the current edition of the following applicable codes as approved by the Board for Licensing Health Care Facilities: International Building Code (excluding Chapters 1 and 11) including referenced International Fuel Gas Code, International Mechanical Code, and International Plumbing Code; National Fire Protection Association (NFPA) NFPA 101 Life Safety Code excluding referenced NFPA 5000; Guidelines for Design and Construction of Health Care Facilities (FGI) including referenced Codes and Standards; U.S. Public Health Service Food Code; and Americans with Disabilities Act (ADA) Standards for Accessible Design. When referring to height, area or construction type, the International Building Code shall prevail. Where there are conflicts between requirements in local codes, the above listed codes, regulations and provisions of this chapter, the most stringent requirements shall apply.
- (3) The codes in effect at the time of submittal of plans and specifications, as defined by these rules, shall be the codes to be used throughout the project.
- (4) The licensed contractor shall perform all new construction and renovations to RHAs, other than minor alterations not affecting fire and life safety or functional issues, in accordance with

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the specific requirements of these regulations governing new construction in RHAs, including the submission of phased construction plans and the final drawings and the specifications to each.

- (5) No new RHA shall be constructed, nor shall major alterations be made to an existing RHA without prior written approval of the department, and unless in accordance with plans and specifications approved in advance by the department. Before any new RHA is licensed or before any alteration or expansion of a licensed RHA can be approved, the applicant must furnish two (2) complete sets of plans and specifications to the department, together with fees and other information as required. Plans and specifications for new construction and major renovations, other than minor alterations not affecting fire and life safety or functional issues, shall be prepared by or under the direction of a licensed architect and/or a licensed engineer and in accordance with the rules of the Board of Architectural and Engineering Examiners.
- (6) Final working drawings and specifications shall be accurately dimensioned and include all necessary explanatory notes, schedules and legends. The working drawings and specifications shall be complete and adequate for contract purposes.
- (7) Detailed plans shall be drawn to a scale of at least one-eighth inch equals one foot ($1/8" = 1'$), and shall show the general arrangement of the building, the intended purpose and the fixed equipment in each room, with such additional information as the department may require. An architect or engineer licensed to practice in the State of Tennessee shall prepare the plans the department requires.
 - (a) The project architect or engineer shall forward two (2) sets of plans to the appropriate section of the department for review. After receipt of approval of phased construction plans, the owner may proceed with site grading and foundation work prior to receipt of approval of final plans and specifications with the owner's understanding that such work is at the owner's own risk and without assurance that final approval of final plans and specifications shall be granted. The project architect or engineer shall submit final plans and specifications for review and approval. The department must grant final approval before the project proceeds beyond foundation work.
 - (b) Review of plans does not eliminate responsibility of owner and/or architect to comply with all rules and regulations.
- (8) Specifications shall supplement all drawings. They shall describe the characteristics of all materials, products and devices, unless fully described and indicated on the drawings. Specification copies should be bound in an 8½ x 11 inch folder.
- (9) Drawings and specifications shall be prepared for each of the following branches of work: Architectural, Structural, Mechanical, Electrical and Sprinkler.
- (10) Architectural drawings shall include where applicable:
 - (a) Plot plan(s) showing property lines, finish grade, location of existing and proposed structures, roadways, walks, utilities and parking areas;
 - (b) Floor plan(s) showing scale drawings of typical and special rooms, indicating all fixed and movable equipment and major items of furniture;
 - (c) Separate life safety plans showing the compartment(s), all means of egress and exit markings, exits and travel distances, dimensions of compartments and calculation and tabulation of exit units. All fire and smoke walls must be identified;

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- (d) The elevation of each facade;
 - (e) The typical sections throughout the building;
 - (f) The schedule of finishes;
 - (g) The schedule of doors and windows;
 - (h) Roof plans;
 - (i) Details and dimensions of elevator shaft(s), car platform(s), doors, pit(s), equipment in the machine room, and the rates of car travel must be indicated for elevators; and
 - (j) Code analysis.
- (11) Structural drawings shall include where applicable:
- (a) Plans of foundations, floors, roofs and intermediate levels which show a complete design with sizes, sections and the relative location of the various members;
 - (b) Schedules of beams, girders and columns; and
 - (c) Design live load values for wind, roof, floor, stairs, guard, handrails, and seismic.
- (12) Mechanical drawings shall include where applicable:
- (a) Specifications which show the complete heating, ventilating, fire protection, medical gas systems and air conditioning systems;
 - (b) Water supply, sewerage and HVAC piping systems;
 - (c) Pressure relationships shall be shown on all floor plans;
 - (d) Heating, ventilating, HVAC piping, medical gas systems and air conditioning systems with all related piping and auxiliaries to provide a satisfactory installation;
 - (e) Water supply, sewage and drainage with all lines, risers, catch basins, manholes and cleanouts clearly indicated as to location, size, capacities, etc., and location and dimensions of septic tank and disposal field; and
 - (f) Color coding to show clearly supply, return and exhaust systems.
- (13) Electrical drawings shall include where applicable:
- (a) A seal, certifying that all electrical work and equipment is in compliance with all applicable codes and that all materials are currently listed by recognized testing laboratories;
 - (b) All electrical wiring, outlets, riser diagrams, switches, special electrical connections, electrical service entrance with service switches, service feeders and characteristics of the light and power current, and transformers when located within the building;
 - (c) An electrical system that complies with applicable codes;
 - (d) Color coding to show all items on emergency power;

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- (e) Circuit breakers that are properly labeled; and
 - (f) Ground-Fault Circuit Interrupters (GFCI) that are required in all wet areas, such as kitchens, laundries, janitor closets, bath and toilet rooms, etc, and within six (6) feet of any lavatory.
- (14) The electrical drawings shall not include knob and tube wiring, shall not include electrical cords that have splices, and shall not show that the electrical system is overloaded.
- (15) In all new facilities or renovations to existing electrical systems, the installation must be approved by an inspector or agency authorized by the State Fire Marshal.
- (16) Sprinkler drawings shall include where applicable:
- (a) Shop drawings, hydraulic calculations, and manufacturer cut sheets;
 - (b) Site plan showing elevation of fire hydrant to building, test hydrant, and flow data (Data from within a 12 month period); and
 - (c) Show "Point of Service" where water is used exclusively for fire protection purposes.
- (17) The licensed contractor shall not install a system of water supply, plumbing, sewage, garbage or refuse disposal nor materially alter or extend any existing system until the architect or engineer submits complete plans and specifications for the installation, alteration or extension to the department demonstrating that all applicable codes have been met and the department has granted necessary approval.
- (a) Before the RHA is used, Tennessee Department of Environment and Conservation shall approve the water supply system.
 - (b) Sewage shall be discharged into a municipal system or approved package system where available; otherwise, the sewage shall be treated and disposed of in a manner of operation approved by the Department of Environment and Conservation and shall comply with existing codes, ordinances and regulations which are enforced by cities, counties or other areas of local political jurisdiction.
 - (c) Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at shower, bathing and hand washing facilities shall be between 105°F and 115°F.
- (18) It shall be demonstrated through the submission of plans and specifications that in each RHA:
- (a) A negative air pressure shall be maintained in the soiled utility area, toilet room, janitor's closet, dishwashing and other such soiled spaces, and a positive air pressure shall be maintained in all clean areas including, but not limited to, clean linen rooms and clean utility rooms;
 - (b) A minimum of eighty (80) square feet of bedroom space must be provided each resident. No bedroom shall have more than two (2) beds. Privacy screens or curtains must be provided and used when required by the resident;
 - (c) Living room and dining areas capable of accommodating all residents shall be provided, with a minimum of fifteen (15) square feet per resident per dining area; and

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- (d) Each toilet, lavatory, bath or shower shall serve no more than six (6) persons. Grab bars and non-slip surfaces shall be installed at tubs and showers.

- (19) The department shall acknowledge that it has reviewed plans and specifications in writing with copies sent to the project architect, the project engineer, the owner, the manager or other executive of the institution. The department may modify the distribution of such review at its discretion.

- (20) In the event submitted materials do not appear to satisfactorily comply with 1200-08-11-.07(2), the department shall furnish a letter to the party submitting the plans which shall list the particular items in question and request further explanation and/or confirmation of necessary modifications.

- (21) The licensed contractor shall execute all construction in accordance with the approved plans and specifications.

- (22) If construction begins within one hundred eighty (180) days of the date of department approval, the department's written notification of satisfactory review constitutes compliance with 1200-08-11-.07(2). This approval shall in no way permit and/or authorize any omission or deviation from the requirements of any restrictions, laws, regulations, ordinances, codes or rules of any responsible agency.

- (23) Prior to final inspection, a CD Rom disc, in TIF or PDF format, of the final approved plans including all shop drawings, sprinkler, calculations, hood and duct, addenda, specifications, etc., shall be submitted to the department.

- (24) The department requires the following alarms that shall be monitored twenty-four (24) hours per day:
 - (a) Fire alarms; and
 - (b) Generators (if applicable).

- (25) With the submission of plans the facility shall specify the evacuation capabilities of the patients as defined in the National Fire Protection Code (NFPA). This declaration will determine the design and construction requirements of the facility.

- (26) Each RHA shall ensure that an emergency keyed lock box is installed next to each bank of functioning elevators located on the main level. Such lock boxes shall be permanently mounted seventy-two inches (72") from the floor to the center of the box, be operable by a universal key no matter where such box is located, and shall contain only fire service keys and drop keys to the appropriate elevators.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, and 68-11-261.
Administrative History: Original rule filed June 21, 1979; effective August 6, 1979. Amendment filed August 16, 1988; effective September 30, 1988. Amendment filed January 30, 1992; effective March 15, 1992. Amendment filed December 7, 1993; effective February 20, 1994. Amendment filed January 6, 1995; effective March 22, 1995. Repeal and new rule filed July 27, 2000; effective October 10, 2000. Amendment filed February 18, 2003; effective May 4, 2003. Amendment filed September 6, 2006; effective November 22, 2006. Amendment filed February 23, 2007; effective May 9, 2007. Repeal and new rule filed December 20, 2011; effective March 19, 2012. Amendment filed January 21, 2016; effective April 20, 2016.

1200-08-11-.08 LIFE SAFETY.

- (1) Any residential home for the aged which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.
- (2) The residential home for the aged shall provide fire protection by the elimination of fire hazards, by the installation of necessary fire fighting equipment and by the adoption of a written fire control plan. Fire drills shall be held at least quarterly for each work shift for residential home for the aged personnel in each separate building. There shall be one fire drill per quarter during sleeping hours. There shall be a written report documenting the evaluation of each drill and the action recommended or taken for any deficiencies found. Records which document and evaluate these drills must be maintained for at least three (3) years. All fires which result in a response by the local fire department shall be reported to the department within seven (7) days. The report shall contain sufficient information to ascertain the nature and location of the fire, its probable cause and any injuries incurred by any person or persons as a result of the fire. Initial reports by the facility may omit the name(s) of resident(s) and parties involved, however, should the department find the identities of such persons to be necessary to an investigation, the facility shall provide such information.
- (3) Residents who cannot evacuate within thirteen (13) minutes may be retained in the facility so long as such residents are retained in designated areas in accordance with of the Standard Building Code and the National Fire Protection Code (NFPA).
- (4) Each resident's room shall have a door that opens directly to the outside or a corridor which leads directly to an exit door and must always be capable of being unlocked by the resident.
- (5) Doors to residents' rooms shall not be louvered.
- (6) Corridors shall be lighted at all times, to a minimum of one foot candle.
- (7) General lighting and night lighting shall be provided for each resident. Night lighting shall be equipped with emergency power.
- (8) Corridors and exit doors shall be kept clear of equipment, furniture and other obstacles at all times. There shall be a clear passage at all times from the exit doors to a safe area.
- (9) Combustible finishes and furnishings shall not be used.
- (10) Open flame and portable space heaters shall not be permitted in the home. Cooking appliances other than microwave ovens shall not be allowed in sleeping rooms.
- (11) All heaters shall be guarded and spaced to prevent ignition of combustible material and accidental burns. The guard shall not have a surface temperature greater than 120° F.
- (12) Fireplaces and/or fireplace inserts may be used only if provided with guards or screens which are secured in place. Fireplaces and chimneys shall be inspected and cleaned annually and verified documentation shall be maintained.
- (13) All electrical equipment shall be maintained in good repair and in safe operating condition.
- (14) Electrical cords shall not be run under rugs or carpets.
- (15) The electrical systems shall not be overloaded. Power strips must be equipped with circuit breakers. Extension cords shall not be used.

(Rule 1200-08-11-.08, continued)

- (16) All facilities must have electrically-operated smoke detectors with battery back-up power operating at all times in, at least, sleeping rooms, day rooms, corridors, laundry room, and any other hazardous areas.
- (17) Fire extinguishers, complying with NFPA 10, shall be provided and mounted so they are accessible to all residents in the kitchen, laundries and at all exits. Extinguishers in the kitchen and laundries shall be a minimum of 2-A: 10-BC and an extinguisher with a rating of 20-A shall be adjacent to every hazardous area. The minimum travel distance shall not exceed fifty (50) feet between the extinguishers.
- (18) Smoking and smoking materials shall be permitted only in designated areas under supervision. Ashtrays must be provided wherever smoking is permitted. Smoking in bed is prohibited. The facility shall have written policies and procedures for smoking within the facility which shall designate a room or rooms to be used exclusively for residents who smoke. The designated smoking room or rooms shall not be the dining room or activity room.
- (19) No smoking signs shall be posted in areas where oxygen is used or stored.
- (20) Trash and other combustible waste shall not be allowed to accumulate within and around the home and shall be stored in appropriate containers with tight-fitting lids. Resident rooms shall be furnished with a UL approved trash container.
- (21) All safety equipment shall be maintained in good repair and in a safe operating condition.
- (22) Janitorial supplies shall not be stored in the kitchen, food storage area, dining area or resident accessible areas.
- (23) Flammable liquids shall be stored in approved containers and stored away from the living areas of the facility.
- (24) Floor and dryer vents shall be cleaned as frequently as needed to prevent accumulation of lint, soil and dirt.
- (25) Emergency telephone numbers must be posted near a telephone accessible to the residents.
- (26) The physical environment shall be maintained in a safe, clean and sanitary manner.
 - (a) Any condition on the facility site conducive to the harboring or breeding of insects, rodents or other vermin shall be prohibited. Chemical substances of a poisonous nature used to control or eliminate vermin shall be properly identified. Such substances shall not be stored with or near food or medications.
 - (b) The building shall not become overcrowded with a combination of the facility's residents and other occupants.
 - (c) Each resident bedroom shall contain a chair, bed, mattress, springs, linens, chest of drawers and wardrobe or closet space, either provided by the facility or by the resident if the resident prefers. All furniture provided by the resident must meet NFPA. All resident's clothing must be maintained in good repair and suitable for the use of elderly persons.
 - (d) The building and its heating, cooling, plumbing and electrical systems shall be maintained in good repair and a clean condition at all times.

(Rule 1200-08-11-.08, continued)

- (e) Temperatures in residents' rooms and common areas shall not be less than 65°F and no more than 85°F.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.
Administrative History: Original rule filed June 21, 1979; effective August 6, 1979. Amendment filed August 16, 1988; effective September 30, 1988. Amendment filed January 39, 1992; effective March 15, 1992. Repeal and new rule filed July 27, 2000; effective October 10, 2000. Amendment filed September 6, 2006; effective November 6, 2006.

1200-08-11-.09 INFECTIOUS AND HAZARDOUS WASTE.

- (1) Each home for the aged must develop, maintain and implement written policies and procedures for the definition and handling of its infectious waste. These policies and procedures must comply with the standards of this section.
- (2) The following waste shall be considered to be infectious waste:
 - (a) Waste contaminated by residents who are isolated due to communicable disease, as provided in the U.S. Centers for Disease Control "Guidelines for Isolation Precautions in Hospitals";
 - (b) Cultures and stocks of infectious agents including specimen cultures collected from medical and pathological laboratories, cultures and stocks of infectious agents from research and industrial laboratories, wastes from the production of biologicals, discarded live and attenuated vaccines, and culture dishes and devices used to transfer, inoculate, and mix cultures;
 - (c) Waste human blood and blood products such as serum, plasma, and other blood components;
 - (d) Pathological waste, such as tissues, organs, body parts, and body fluids that are removed during surgery and autopsy;
 - (e) All discarded sharps (including but not limited to, hypodermic needles, syringes, pasteur pipettes, broken glass, scalpel blades) used in resident care or which have come into contact with infectious agents during use in medical, research, or industrial laboratories;
 - (f) Other waste determined to be infectious by the facility in its written policy.
- (3) Infectious and hazardous waste must be segregated from other waste at the point of generation (i.e., the point at which the material becomes a waste) within the facility.
- (4) Waste must be packaged in a manner that will protect waste handlers and the public from possible injury and disease that may result from exposure to the waste. Such packaging must provide for containment of the waste from the point of generation up to the point of proper treatment or disposal. Packaging must be selected and utilized for the type of waste the packages will contain, how the waste will be treated and disposed, and how it will be handled and transported, prior to treatment and disposal.
 - (a) Contaminated sharps must be directly placed in leakproof, rigid, and puncture-resistant containers which must be tightly sealed.
 - (b) Whether disposable or reusable, all containers, bags, and boxes used for containment and disposal of infectious waste must be conspicuously identified. Packages containing infectious waste which pose additional hazards (including but not limited to, chemical,

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- radiologicals) must also be conspicuously identified to clearly indicate those additional hazards.
- (c) Reusable containers for infectious waste must be thoroughly sanitized each time they are emptied, unless the surfaces of the containers have been completely protected from contamination by disposable liners or other devices removed with the waste.
 - (d) Opaque packaging must be used for pathological waste.
- (5) After packaging, waste must be handled and transported by methods ensuring containment and preservation of the integrity of the packaging, including the use of secondary containment where necessary. Plastic bags of infectious waste must be transported by hand.
- (6) Waste must be stored in a manner which preserves the integrity of the packaging, inhibits rapid microbial growth and putrefaction, and minimizes the potential of exposure or access by unknowing persons.
- (a) Waste must be stored in a manner and location which affords protection from animals, precipitation, wind, and direct sunlight, does not present a safety hazard, does not provide a breeding place or food source for insects or rodents, and does not create a nuisance.
 - (b) Pathological waste must be promptly treated, disposed of, or placed into refrigerated storage.
- (7) In the event of spills, ruptured packaging, or other incidents where there is a loss of containment of waste, the facility must ensure that proper actions are immediately taken to:
- (a) Isolate the area from the public and non-essential personnel;
 - (b) To the extent practicable, repackage all spilled waste and contaminated debris in accordance with the requirements of paragraph 6 of this section;
 - (c) Sanitize all contaminated equipment and surfaces according to written policies and procedures which specify how this will be done appropriately; and,
 - (d) Complete an incident report and maintain a copy on file.
- (8) Except as provided otherwise in this rule, a facility must treat or dispose of infectious waste by one or more of the methods specified in this paragraph.
- (a) A facility may treat infectious waste in an on-site sterilization or disinfection device, or in an incinerator or a steam sterilizer, which has been designed, constructed, operated and maintained so that infectious waste treated in such a device is rendered non-infectious and is, if applicable, authorized for that purpose pursuant to current rules of the Department of Environment and Conservation. A valid permit or other written evidence of having complied with the Tennessee Air Pollution Control Regulations shall be available for review, if required. Each sterilizing or disinfecting cycle must contain appropriate indicators to assure that conditions were met for proper sterilization or disinfection or materials included in the cycle, and appropriate records kept. Proper operation of such devices must be verified at least monthly, and records of the monthly verifications shall be available for review. Waste that contains toxic chemicals that would be volatilized by steam must not be treated in steam sterilizers. Infectious waste that has been rendered to carbonized or mineralized ash shall be deemed non-infectious. Unless otherwise hazardous and subject to the hazardous waste management requirements of the current rules of the Department of Environment and

(Rule 1200-08-11-.09, continued)

Conservation, such ash shall be disposable as a (non-hazardous) solid waste under current rules of the Department of Environment and Conservation.

- (b) A facility may discharge liquid or semi-liquid infectious waste to the collection sewerage system of a wastewater treatment facility which is subject to a permit pursuant to T.C.A. §§ 69-3-101, et seq., provided that such discharge is in accordance with any applicable terms of that permit and/or any applicable municipal sewer use requirements.
 - (c) Any health care facility accepting waste from another state must promptly notify the Department of Environment and Conservation, county, and city public health agencies, and must strictly comply with all applicable local, state and federal regulations.
- (9) The facility may have waste transported off-site for storage, treatment, or disposal. Such arrangements must be detailed in a written contract, available for review. If such off-site location is located within Tennessee, the facility must ensure that it has all necessary State and local approvals, and such approvals shall be available for review. If the off-site location is within another state, the facility must notify in writing all public health agencies with jurisdiction that the location is being used for management of the facility's waste. Waste shipped off-site must be packaged in accordance with applicable federal and state requirements. Waste transported to a sanitary landfill in this state must meet the requirements of current rules of the Department of Environment and Conservation.
- (10) Human anatomical remains which are transferred to a mortician for cremation or burial shall be exempt from the requirements of this rule.
- (11) All garbage, trash and other non-infectious waste shall be stored and disposed of in a manner that must not permit the transmission of disease, create a nuisance, provide a breeding place for insects and rodents, or constitute a safety hazard. All containers for waste shall be water tight, constructed of easily-cleanable material, and shall be kept on elevated platforms.

Authority: T.C.A. §§ 4-5-202 through 4-5-206, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.

Administrative History: Original rule filed June 21, 1979; effective August 6, 1979. Repeal and new rule filed July 27, 2000; effective October 10, 2000.

1200-08-11-.10 RECORDS AND REPORTS.

- (1) An individual resident file shall be maintained for each resident in the home. Personal information shall be confidential and shall not be disclosed, except to the resident, the department and others with written authorization from the resident. These files shall be retained for one (1) year after the resident is transferred or discharged. The resident file shall include:
- (a) Name, Social Security Number, veteran status and number, marital status, age, sex, previous address and any health insurance provider and number, including Medicare and Medicaid numbers;
 - (b) Name, address and telephone number of next of kin, legal guardian and any other person identified by the resident to contact on his/her behalf;
 - (c) Name, address and telephone number of any person or agency providing additional services to the resident;
 - (d) Date of admission, transfer, discharge and any new forwarding address;

(Rule 1200-08-11-.10, continued)

- (e) Name and address of the resident's preferred physician, hospital, pharmacist, assisted care living facility and nursing home, and any other instructions from the resident to be followed in case of emergency;
 - (f) Record of all monies and other valuables entrusted to the home for safekeeping, with appropriate updates;
 - (g) Health information including all current prescriptions, major changes in resident's habits or health status, results of physician's visits, and any health care instructions; and
 - (h) A copy of the admission agreement signed and dated by the resident.
- (2) The RHA shall report all incidents of abuse, neglect, and misappropriation to the Department of Health in accordance with T.C.A. § 68-11-211.
- (3) The RHA shall report the following incidents to the Department of Health in accordance with T.C.A. § 68-11-211.
- (a) Strike by staff at the facility;
 - (b) External disasters impacting the facility;
 - (c) Disruption of any service vital to the continued safe operation of the RHA or to the health and safety of its residents and personnel; and
 - (d) Fires at the RHA that disrupt the provision of resident services or cause harm to the residents or staff, or that are reported by the facility to any entity, including but not limited to a fire department charged with preventing fires.
- (4) Legible copies of the following records and reports shall be retained in the facility, shall be maintained in a single file, and shall be made available for inspection during normal business hours for thirty-six (36) months following their issuance. Each resident and each person assuming any financial responsibility for a resident must be fully informed, before admission, of their existence in the home and given the opportunity to inspect the file before entering into any monetary agreement with the facility.
- (a) Local fire safety inspections;
 - (b) Local building code inspections, if any;
 - (c) Department licensure and fire safety inspections and surveys;
 - (d) Orders of the Commissioner or Board, if any; and
 - (e) Maintenance records of all safety equipment.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-207, 68-11-209, 68-11-210, 68-11-211, and 68-11-213. **Administrative History:** Original rule filed June 21, 1979; effective August 6, 1979. Amendment filed February 26, 1985; effective March 28, 1985. Amendment filed August 16, 1988; effective September 30, 1988. Repeal and new rule filed July 27, 2000; effective October 10, 2000. Amendment filed April 11, 2003; effective June 25, 2003. Amendment filed December 23, 2009; effective March 23, 2010. Amendments filed January 3, 2012; effective April 2, 2012.

1200-08-11-.11 RESIDENT RIGHTS. Each resident has at least the following rights:

- (1) To privacy in treatment and personal care;

(Rule 1200-08-11-.11, continued)

- (2) To be free from mental and physical abuse. Should this right be violated, the facility must notify the department within five (5) working days. The Tennessee Department of Human Services, Adult Protective Services shall be notified immediately as required in T.C.A. § 71-6-103;
- (3) To refuse treatment. The resident must be informed of the consequences of that decision, and the refusal and its reason must be reported to the physician and documented in the resident's record;
- (4) To have his or her file kept confidential and private. Written consent by the resident must be obtained prior to release of information except to persons authorized by law;
- (5) To be fully informed of the Resident's Rights, of any policies and procedures governing resident conduct, any services available in the home and the schedule of all fees for all services;
- (6) To participate in drawing up the terms of the admission agreement, including providing for the resident's preferences for physician care, hospitalization, assisted living facility care, nursing home care, acquisition of medication, emergency plans and funeral arrangements;
- (7) To be given thirty (30) days written notice prior to transfer or discharge, except when ordered by any physician because a higher level of care is required;
- (8) To voice grievances and recommend changes in policies and services of the home with freedom from restraint, interference, coercion, discrimination or reprisal. The resident shall be informed of procedures for registering complaints confidentially and to voice grievances;
- (9) To manage his or her personal financial affairs, including the right to keep and spend his or her own money. If the resident requests assistance from the home in managing his or her personal financial affairs, the request must be in writing and may be terminated by the resident at any time. The home must separate such monies from the home's operating funds and all other deposits or expenditures, submit a written accounting to the resident at least quarterly, and immediately return the balance upon transfer or discharge. A current copy of this report shall be maintained in the resident's file maintained by the licensee;
- (10) To be treated with consideration, respect and full recognition of his or her dignity and individuality;
- (11) To be accorded privacy for sleeping and for storage space for personal belongings;
- (12) To have free access to day rooms, dining and other group living or common areas at reasonable hours and to come and go from the home, unless such access infringes upon the rights of other residents or unless the resident is admitted to the secured unit;
- (13) To wear his or her own clothes, to keep and use his or her own toilet articles and personal possessions;
- (14) To send and receive unopened mail;
- (15) To associate and communicate privately with persons of his or her choice, including receiving visitors at reasonable hours;
- (16) To participate or to refuse to participate in community activities, including cultural, educational, religious, community service, vocational and recreational activities;

(Rule 1200-08-11-.11, continued)

- (17) To not be required to perform services for the home. The resident and licensee may mutually agree, in writing, for the resident to perform certain activities or services as part of the fee for his or her stay; and,
- (18) To execute, modify, or rescind a Living Will.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.
Administrative History: Original rule filed June 21, 1997; effective August 6, 1979. Amendment filed August 16, 1988; effective September 30, 1988. Repeal and new rule filed July 27, 2000; effective October 10, 2000.

1200-08-11-.12 POLICIES AND PROCEDURES FOR HEALTH CARE DECISION-MAKING.

- (1) Pursuant to this Rule, each home for the aged shall maintain and establish policies and procedures governing the designation of a health care decision-maker for making health care decisions for a resident who is incompetent or who lacks capacity, including but not limited to allowing the withholding of CPR measures from individual residents. An adult or emancipated minor may give an individual instruction. The instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.
- (2) An adult or emancipated minor may execute an advance directive for health care. The advance directive may authorize an agent to make any health care decision the resident could have made while having capacity, or may limit the power of the agent, and may include individual instructions. The effect of an advance directive that makes no limitation on the agent's authority shall be to authorize the agent to make any health care decision the resident could have made while having capacity.
- (3) The advance directive shall be in writing, signed by the resident, and shall either be notarized or witnessed by two (2) witnesses. Both witnesses shall be competent adults, and neither of them may be the agent. At least one (1) of the witnesses shall be a person who is not related to the resident by blood, marriage, or adoption and would not be entitled to any portion of the estate of the resident upon the death of the resident. The advance directive shall contain a clause that attests that the witnesses comply with the requirements of this paragraph.
- (4) Unless otherwise specified in an advance directive, the authority of an agent becomes effective only upon a determination that the resident lacks capacity, and ceases to be effective upon a determination that the resident has recovered capacity.
- (5) A facility may use any advanced directive form that meets the requirements of the Tennessee Health Care Decisions Act or has been developed and issued by the Board for Licensing Health Care Facilities.
- (6) A determination that a resident lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent shall be made by the designated physician, who is authorized to consult with such other persons as he or she may deem appropriate.
- (7) An agent shall make a health care decision in accordance with the resident's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the resident's best interest. In determining the resident's best interest, the agent shall consider the resident's personal values to the extent known.
- (8) An advance directive may include the individual's nomination of a court-appointed guardian.

(Rule 1200-08-11-.12, continued)

- (9) A health care facility shall honor an advance directive that is executed outside of this state by a nonresident of this state at the time of execution if that advance directive is in compliance with the laws of Tennessee or the state of the resident's residence.
- (10) No health care provider or institution shall require the execution or revocation of an advance directive as a condition for being insured for, or receiving, health care.
- (11) Any living will, durable power of attorney for health care, or other instrument signed by the individual, complying with the terms of Tennessee Code Annotated, Title 32, Chapter 11, and a durable power of attorney for health care complying with the terms of Tennessee Code Annotated, Title 34, Chapter 6, Part 2, shall be given effect and interpreted in accord with those respective acts. Any advance directive that does not evidence an intent to be given effect under those acts but that complies with these regulations may be treated as an advance directive under these regulations.
- (12) A resident having capacity may revoke the designation of an agent only by a signed writing or by personally informing the supervising health care provider.
- (13) A resident having capacity may revoke all or part of an advance directive, other than the designation of an agent, at any time and in any manner that communicates an intent to revoke.
- (14) A decree of annulment, divorce, dissolution of marriage, or legal separation revokes a previous designation of a spouse as an agent unless otherwise specified in the decree or in an advance directive.
- (15) An advance directive that conflicts with an earlier advance directive revokes the earlier directive to the extent of the conflict.
- (16) Surrogates.
 - (a) An adult or emancipated minor may designate any individual to act as surrogate by personally informing the supervising health care provider. The designation may be oral or written.
 - (b) A surrogate may make a health care decision for a resident who is an adult or emancipated minor if and only if:
 1. The resident has been determined by the designated physician to lack capacity, and
 2. No agent or guardian has been appointed, or
 3. The agent or guardian is not reasonably available.
 - (c) In the case of a resident who lacks capacity, the resident's surrogate shall be identified by the supervising health care provider and documented in the current clinical record of the facility at which the resident is receiving health care.
 - (d) The resident's surrogate shall be an adult who has exhibited special care and concern for the resident, who is familiar with the resident's personal values, who is reasonably available, and who is willing to serve.
 - (e) Consideration may be, but need not be, be given in order of descending preference for service as a surrogate to:

(Rule 1200-08-11-.12, continued)

1. The resident's spouse, unless legally separated;
 2. The resident's adult child;
 3. The resident's parent;
 4. The resident's adult sibling;
 5. Any other adult relative of the resident; or
 6. Any other adult who satisfies the requirements of 1200-08-11-.12(16)(d).
- (f) No person who is the subject of a protective order or other court order that directs that person to avoid contact with the resident shall be eligible to serve as the resident's surrogate.
- (g) The following criteria shall be considered in the determination of the person best qualified to serve as the surrogate:
1. Whether the proposed surrogate reasonably appears to be better able to make decisions either in accordance with the known wishes of the resident or in accordance with the resident's best interests;
 2. The proposed surrogate's regular contact with the resident prior to and during the incapacitating illness;
 3. The proposed surrogate's demonstrated care and concern;
 4. The proposed surrogate's availability to visit the resident during his or her illness; and
 5. The proposed surrogate's availability to engage in face-to-face contact with health care providers for the purpose of fully participating in the decision-making process.
- (h) If the resident lacks capacity and none of the individuals eligible to act as a surrogate under 1200-08-11-.12(16)(c) through 1200-08-11-.12(16)(g) is reasonably available, the designated physician may make health care decisions for the resident after the designated physician either:
1. Consults with and obtains the recommendations of a facility's ethics mechanism or standing committee in the facility that evaluates health care issues; or
 2. Obtains concurrence from a second physician who is not directly involved in the resident's health care, does not serve in a capacity of decision-making, influence, or responsibility over the designated physician, and is not under the designated physician's decision-making, influence, or responsibility.
- (i) In the event of a challenge, there shall be a rebuttable presumption that the selection of the surrogate was valid. Any person who challenges the selection shall have the burden of proving the invalidity of that selection.
- (j) A surrogate shall make a health care decision in accordance with the resident's individual instructions, if any, and other wishes to the extent known to the surrogate. Otherwise, the surrogate shall make the decision in accordance with the surrogate's determination of the resident's best interest. In determining the resident's best interest,

(Rule 1200-08-11-.12, continued)

the surrogate shall consider the resident's personal values to the extent known to the surrogate.

- (k) A surrogate who has not been designated by the resident may make all health care decisions for the resident that the resident could make on the resident's own behalf, except that artificial nutrition and hydration may be withheld or withdrawn for a resident upon a decision of the surrogate only when the designated physician and a second independent physician certify in the resident's current clinical records that the provision or continuation of artificial nutrition or hydration is merely prolonging the act of dying and the resident is highly unlikely to regain capacity to make medical decisions.
 - (l) Except as provided in 1200-08-11-.12(16)(m):
 - 1. Neither the treating health care provider nor an employee of the treating health care provider, nor an operator of a health care institution nor an employee of an operator of a health care institution may be designated as a surrogate; and
 - 2. A health care provider or employee of a health care provider may not act as a surrogate if the health care provider becomes the resident's treating health care provider.
 - (m) An employee of the treating health care provider or an employee of an operator of a health care institution may be designated as a surrogate if:
 - 1. The employee so designated is a relative of the resident by blood, marriage, or adoption; and
 - 2. The other requirements of this section are satisfied.
 - (n) A health care provider may require an individual claiming the right to act as surrogate for a resident to provide written documentation stating facts and circumstances reasonably sufficient to establish the claimed authority.
- (17) Guardian.
- (a) A guardian shall comply with the resident's individual instructions and may not revoke the resident's advance directive absent a court order to the contrary.
 - (b) Absent a court order to the contrary, a health care decision of an agent takes precedence over that of a guardian.
 - (c) A health care provider may require an individual claiming the right to act as guardian for a resident to provide written documentation stating facts and circumstances reasonably sufficient to establish the claimed authority.
- (18) A designated physician who makes or is informed of a determination that a resident lacks or has recovered capacity, or that another condition exists which affects an individual instruction or the authority of an agent, guardian, or surrogate, shall promptly record the determination in the resident's current clinical record and communicate the determination to the resident, if possible, and to any person then authorized to make health care decisions for the resident.
- (19) Except as provided in 1200-08-11-.12(20) through 1200-08-11-.12(22), a health care provider or institution providing care to a resident shall:

(Rule 1200-08-11-.12, continued)

- (a) Comply with an individual instruction of the resident and with a reasonable interpretation of that instruction made by a person then authorized to make health care decisions for the resident; and
 - (b) Comply with a health care decision for the resident made by a person then authorized to make health care decisions for the resident to the same extent as if the decision had been made by the resident while having capacity.
- (20) A health care provider may decline to comply with an individual instruction or health care decision for reasons of conscience.
- (21) A health care institution may decline to comply with an individual instruction or health care decision if the instruction or decision is:
- (a) Contrary to a policy of the institution which is based on reasons of conscience, and
 - (b) The policy was timely communicated to the resident or to a person then authorized to make health care decisions for the resident.
- (22) A health care provider or institution may decline to comply with an individual instruction or health care decision that requires medically inappropriate health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution.
- (23) A health care provider or institution that declines to comply with an individual instruction or health care decision pursuant to 1200-08-11-.12(20) through 1200-08-11-.12(22) shall:
- (a) Promptly so inform the resident, if possible, and any person then authorized to make health care decisions for the resident;
 - (b) Provide continuing care to the resident until a transfer can be effected or until the determination has been made that transfer cannot be effected;
 - (c) Unless the resident or person then authorized to make health care decisions for the resident refuses assistance, immediately make all reasonable efforts to assist in the transfer of the resident to another health care provider or institution that is willing to comply with the instruction or decision; and
 - (d) If a transfer cannot be effected, the health care provider or institution shall not be compelled to comply.
- (24) Unless otherwise specified in an advance directive, a person then authorized to make health care decisions for a resident has the same rights as the resident to request, receive, examine, copy, and consent to the disclosure of medical or any other health care information.
- (25) A health care provider or institution acting in good faith and in accordance with generally accepted health care standards applicable to the health care provider or institution is not subject to civil or criminal liability or to discipline for unprofessional conduct for:
- (a) Complying with a health care decision of a person apparently having authority to make a health care decision for a resident, including a decision to withhold or withdraw health care;
 - (b) Declining to comply with a health care decision of a person based on a belief that the person then lacked authority; or

(Rule 1200-08-11-.12, continued)

- (c) Complying with an advance directive and assuming that the directive was valid when made and had not been revoked or terminated.

- (26) An individual acting as an agent or surrogate is not subject to civil or criminal liability or to discipline for unprofessional conduct for health care decisions made in good faith.

- (27) A person identifying a surrogate is not subject to civil or criminal liability or to discipline for unprofessional conduct for such identification made in good faith.

- (28) A copy of a written advance directive, revocation of an advance directive, or designation or disqualification of a surrogate has the same effect as the original.

- (29) The withholding or withdrawal of medical care from a resident in accordance with the provisions of the Tennessee Health Care Decisions Act shall not, for any purpose, constitute a suicide, euthanasia, homicide, mercy killing, or assisted suicide.

- (30) Physician Orders for Scope of Treatment (POST)
 - (a) Physician Orders for Scope of Treatment (POST) may be issued by a physician for a patient with whom the physician has a bona fide physician-patient relationship, but only:
 - 1. With the informed consent of the patient;
 - 2. If the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon request of and with the consent of the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act; or
 - 3. If the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order and the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act, is not reasonably available, if the physician determines that the provision of cardio pulmonary resuscitation would be contrary to accepted medical standards.

 - (b) A POST may be issued by a physician assistant, nurse practitioner or clinical nurse specialist for a patient with whom such physician assistant, nurse practitioner or clinical nurse specialist has a bona fide physician assistant-patient or nurse-patient relationship, but only if:
 - 1. No physician, who has a bona fide physician-patient relationship with the patient, is present and available for discussion with the patient (or if the patient is a minor or is otherwise incapable of making an informed decision, with the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act);
 - 2. Such authority to issue is contained in the physician assistant's, nurse practitioner's or clinical nurse specialist's protocols;
 - 3. Either:
 - (i) The patient is a resident of a nursing home licensed under Title 68 or an ICF/MR facility licensed under Title 33 and is in the process of being discharged from the nursing home or transferred to another facility at the time the POST is being issued; or

(Rule 1200-08-11-.12, continued)

- (ii) The patient is a hospital patient and is in the process of being discharged from the hospital or transferred to another facility at the time the POST is being issued; and
- 4. Either:
 - (i) With the informed consent of the patient;
 - (ii) If the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon request of and with the consent of the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act; or
 - (iii) If the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order and the agent, surrogate, or other person authorized to consent on the patient's behalf under the Tennessee Health Care Decisions Act, is not reasonably available and such authority to issue is contained in the physician assistant, nurse practitioner or clinical nurse specialist's protocols and the physician assistant or nurse determines that the provision of cardiopulmonary resuscitation would be contrary to accepted medical standards.
- (c) If the patient is an adult who is capable of making an informed decision, the patient's expression of the desire to be resuscitated in the event of cardiac or respiratory arrest shall revoke any contrary order in the POST. If the patient is a minor or is otherwise incapable of making an informed decision, the expression of the desire that the patient be resuscitated by the person authorized to consent on the patient's behalf shall revoke any contrary order in the POST. Nothing in this section shall be construed to require cardiopulmonary resuscitation of a patient for whom the physician or physician assistant or nurse practitioner or clinical nurse specialist determines cardiopulmonary resuscitation is not medically appropriate.
- (d) A POST issued in accordance with this section shall remain valid and in effect until revoked. In accordance with this rule and applicable regulations, qualified emergency medical services personnel; and licensed health care practitioners in any facility, program, or organization operated or licensed by the Board for Licensing Health Care Facilities, the Department of Mental Health and Substance Abuse Services, or the Department of Intellectual and Developmental Disabilities, or operated, licensed, or owned by another state agency, shall follow a POST that is available to such persons in a form approved by the Board for Licensing Health Care Facilities.
- (e) Nothing in these rules shall authorize the withholding of other medical interventions, such as medications, positioning, wound care, oxygen, suction, treatment of airway obstruction or other therapies deemed necessary to provide comfort care or alleviate pain.
- (f) If a person has a do-not-resuscitate order in effect at the time of such person's discharge from a health care facility, the facility shall complete a POST prior to discharge. If a person with a POST is transferred from one health care facility to another health care facility, the health care facility initiating the transfer shall communicate the existence of the POST to qualified emergency medical service personnel and to the receiving facility prior to the transfer. The transferring facility shall provide a copy of the POST that accompanies the patient in transport to the receiving health care facility. Upon admission, the receiving facility shall make the POST a part of the patient's record.

(Rule 1200-08-11-.12, continued)

- (g) These rules shall not prevent, prohibit, or limit a physician from using a written order, other than a POST, not to resuscitate a patient in the event of cardiac or respiratory arrest in accordance with accepted medical practices. This action shall have no application to any do not resuscitate order that is not a POST, as defined in these rules.
- (h) Valid do not resuscitate orders or emergency medical services do not resuscitate orders issued before July 1, 2004, pursuant to then-current law, shall remain valid and shall be given effect as provided in these rules.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, 68-11-209, 68-11-224, and 68-11-1801 through 68-11-1815. **Administrative History:** Original rule filed June 22, 1992; effective August 6, 1992. Repeal and new rule filed July 27, 2000; effective October 10, 2000. Amendment filed April 28, 2003; effective July 12, 2003. Amendment filed September 8, 2006; effective November 22, 2006. Amendment filed February 7, 2007; effective April 23, 2007. Amendments filed January 3, 2012; effective April 2, 2012. Amendments filed March 27, 2015; effective June 25, 2015.

1200-08-11-.13 DISASTER PREPAREDNESS.

- (1) The administration of every facility shall have in effect and available for all supervisory personnel and staff, written copies of the following required disaster plans for the protection of all persons in the event of fire and other emergencies for evacuation to areas of refuge and/or evacuation from the building. A detailed log with staff signatures of training received shall be maintained. All employees shall be trained annually as required in the following plans and shall be kept informed with respect to their duties under the plans. A copy of the plans and the specific emergency numbers related to that type of disaster shall be readily available at all times. Each of the following plans shall be exercised annually:
 - (a) Fire Safety Procedures Plan shall include:
 - 1. Minor fires;
 - 2. Major fires;
 - 3. Fighting the fire;
 - 4. Evacuation procedures; and
 - 5. Staff functions.
 - (b) Tornado/Severe Weather Procedures Plan shall include:
 - 1. Staff duties; and
 - 2. Evacuation procedures.
 - (c) Bomb Threat Procedures Plan:
 - 1. Staff duties;
 - 2. Search team, searching the premises;
 - 3. Notification of authorities;
 - 4. Location of suspicious objects; and

(Rule 1200-08-11-.13, continued)

5. Evacuation procedures.
- (d) Flood Procedure Plan, if applicable:
 1. Staff duties;
 2. Evacuation procedures; and
 3. Safety procedures following the flood.
 - (e) Severe Cold Weather and Severe Hot Weather Procedure Plans:
 1. Staff duties;
 2. Equipment failures;
 3. Evacuation procedures; and
 4. Emergency food service.
 - (f) Earthquake Disaster Procedures Plan:
 1. Staff duties;
 2. Evacuation procedures;
 3. Safety procedures; and
 4. Emergency services.
- (2) All facilities shall participate in the Tennessee Emergency Management Agency local/county emergency plan on an annual basis. Participation includes filling out and submitting a questionnaire on a form to be provided by the Tennessee Emergency Management Agency. Documentation of participation must be maintained and shall be made available to survey staff as proof of participation.
 - (3) For facilities which elect to have an emergency generator, the generator shall be designed to meet the facility's HVAC and essential needs and shall have a minimum of twenty-four (24) hours of fuel designed to operate at its rated load. This requirement shall be coordinated with the Disaster Preparedness Plan or with local resources.
 - (a) All generators shall be exercised for thirty (30) minutes each month under full load, including automatic and manual transfer of equipment.
 - (b) The emergency generator shall be operated at the existing connected load and not on dual power, and a monthly log shall be maintained by the facility. The facility shall have trained staff familiar with the generator's operation.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.
Administrative History: Original rule filed February 9, 1998; effective April 25, 1998. Repeal and new rule filed July 27, 2000; effective October 10, 2000.

1200-08-11-.14 APPENDIX I

(1) Physician Orders for Scope of Treatment (POST) Form

A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED			
Tennessee Physician Orders for Scope of Treatment (POST, sometimes called "POLST") This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, <u>first</u> follow these orders, then contact physician.		Patient's Last Name <hr/> First Name/Middle Initial <hr/> Date of Birth <hr/>	
Section A	<i>Check One Box Only</i>	CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse <u>and</u> is not breathing. <input type="checkbox"/> Resuscitate(CPR) <input type="checkbox"/> Do Not Attempt Resuscitation (DNR / no CPR) (Allow Natural Death) When not in cardiopulmonary arrest, follow orders in B, C, and D.	
Section B	<i>Check One Box Only</i>	MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing. <input type="checkbox"/> Comfort Measures Only. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location. Treatment Plan: Maximize comfort through symptom management. <input type="checkbox"/> Limited Additional Interventions. In addition to care described in Comfort Measures Only above, use medical treatment, antibiotics, IV fluids and cardiac monitoring as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. Treatment Plan: basic medical treatments. <input type="checkbox"/> Full Treatment. In addition to care described in Comfort Measures Only and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. Treatment Plan: Full treatment including in the intensive care unit. Other Instructions: _____	
Section C	<i>Check One</i>	ARTIFICIALLY ADMINISTERED NUTRITION. Oral fluids & nutrition must be offered if feasible. <input type="checkbox"/> No artificial nutrition by tube. <input type="checkbox"/> Defined trial period of artificial nutrition by tube. <input type="checkbox"/> Long-term artificial nutrition by tube. Other Instructions: _____	
Section D	<i>Must be Completed</i>	Discussed with: <input type="checkbox"/> Patient/Resident <input type="checkbox"/> Health care agent <input type="checkbox"/> Court-appointed guardian <input type="checkbox"/> Health care surrogate <input type="checkbox"/> Parent of minor <input type="checkbox"/> Other: _____(Specify)	The Basis for These Orders Is: (Must be completed) <input type="checkbox"/> Patient's preferences <input type="checkbox"/> Patient's best interest (patient lacks capacity or preferences unknown) <input type="checkbox"/> Medical indications <input type="checkbox"/> (Other) _____
Physician/NP/CNS/PA Name (Print)		Physician/NP/CNS/PA Signature	Date
		NP/CNS/PA (Signature at Discharge)	MD/NP/CNS/PA Phone Number:
Signature of Patient, Parent of Minor, or Guardian/Health Care Representative			
Preferences have been expressed to a physician and/or health care professional. It can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your			

(Rule 1200-08-11-.14, continued)

preferences as best understood by your surrogate.

Name (print)	Signature	Relationship (write "self" if patient)	
Agent/Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Directions for Health Care Professionals

Completing POST

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

To be valid, POST must be signed by a physician or, at discharge or transfer from a hospital or long term care facility, by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Persons with DNR in effect at time of discharge must have POST completed by health care facility prior to discharge and copy of POST provided to qualified medical emergency personnel.

Photocopies/faxes of signed POST forms are legal and valid.

Using POST

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation".

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".

A person with capacity, or the Health Care Agent or Surrogate of a person without capacity, can request alternative treatment.

Reviewing POST

This POST should be reviewed if:

- (1) The patient is transferred from one care setting or care level to another, or
- (2) There is a substantial change in the patient's health status, or
- (3) The patient's treatment preferences change.

Draw line through sections A through D and write "VOID" in large letters if POST is replaced or becomes invalid.

(Rule 1200-08-11-.14, continued)

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

(2) Advance Directive for Health Care Form

ADVANCE DIRECTIVE FOR HEALTH CARE*
(Tennessee)

Instructions: Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Part I Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____ Home Phone: _____ Work Phone: _____
Address: _____ Mobile Phone: _____ Other Phone: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____ Home Phone: _____ Work Phone: _____
Address: _____ Mobile Phone: _____ Other Phone: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. I do not give such permission (this form applies only when I no longer have capacity).

Part 2 Indicate Your Wishes for Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "no" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

<input type="checkbox"/>	<input type="checkbox"/>	Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Permanent Confusion: I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Dependent in all Activities of Daily Living: I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.
Yes	No	

(Rule 1200-08-11-.14, continued)

Indicate Your Wishes for Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked “no” above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking “yes” below, I have indicated treatment I want. By marking “no” below, I have indicated treatment I **do not want**.

<input type="checkbox"/>	<input type="checkbox"/>	CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Life Support / Other Artificial Support: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Tube feeding/IV fluids: Use of tubes to deliver food and water to a patient’s stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.
Yes	No	

Part 3 **Other instructions, such as hospice care, burial arrangements, etc.:** _____

(Attach additional pages if necessary)

Part 4 Organ donation: Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

- Any organ/tissue My entire body Only the following organs/tissues: _____

 No organ/tissue donation

SIGNATURE

Part 5 Your signature must **either** be witnessed by two competent adults (“Block A”) **or** by a notary public (“Block B”).

Signature: _____ Date: _____
 (Patient)

Block A Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent or alternate. I witnessed the patient’s signature on this form.

 Signature of witness number 1

2. I am a competent adult who is not named as the agent or alternate. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient’s estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient’s signature on this form.

 Signature of witness number 2

(Rule 1200-08-11-.14, continued)

Block B You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE
 COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____

 Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE: (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1801 through 68-11-815. **Administrative History:** Original rule filed February 16, 2007; effective May 2, 2007. Repeal and new rule filed August 28, 2012; effective November 26, 2012. Amendment filed March 27, 2015; effective June 25, 2015. Amendments filed February 8, 2017; effective May 9, 2017.