

## Fiscal Impact Analysis of Permanent Rule Readoption without Substantial Economic Impact

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Agency: North Carolina Medical Care Commission  
Division of Health Service Regulation  
Acute Care Licensure and Certification Section

Rule Citation(s):

10A NCAC 13B .3801 Nurse Executive  
10A NCAC 13B .3903 Preservation of Medical Records  
10A NCAC 13B .4103 Provision of Emergency Services  
10A NCAC 13B .4104 Medical Director  
10A NCAC 13B .4106 Policies and Procedures  
10A NCAC 13B .4305 Organization of Neonatal Services  
10A NCAC 13B .4603 Surgical and Anesthesia Staff  
10A NCAC 13B .4801 Organization  
10A NCAC 13B .4805 Safety  
10A NCAC 13B .5102 Policy and Procedures  
10A NCAC 13B .5105 Sterile Supply Services  
10A NCAC 13B .5406 Discharge Criteria for Inpatient Rehabilitation Facilities or Units  
10A NCAC 13B .5408 Comprehensive Inpatient Rehabilitation Program Staffing Requirements  
10A NCAC 13B .5411 Physical Facility Requirements/Inpatient Rehabilitation Facilities or Unit  
(see rule text in Appendix A)

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Rulemaking Authority: G.S. 131E-75(b); 131E-79;

Impact Summary: State Government: No Impact  
Local Government: No Impact  
Private Entities: Impact  
Substantial Impact: No Impact

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### Introduction and Purpose

Under authority of G.S. 150B-21-3A, Periodic Review and Expiration of Existing Rules, the Medical Care Commission, Rules Review Commission, and the Joint Legislative Administrative Procedure Oversight Committee approved the Subchapter report with classifications for the rules located at 10A NCAC 13B -- Rules for the Licensing of Hospitals on February 10, 2017, May 18, 2017, and July 22, 2017 respectively. As a result of the periodic review of rules, 40 rules were determined as “Necessary With Substantive Public Interest,” requiring readoption as new rules for this Subchapter. As of July 1, 2021, three phases totaling 26 rules have been readopted by the N.C. Medical Care Commission (MCC), thereby leaving 14 rules for readoption.

There are 120 licensed Hospitals in North Carolina. This fiscal analysis addresses the fourth phase with the remaining 14 rules for readoption following the periodic review of rules. Fives rules were revised with substantive changes to update practices and language, address previous Rule Review Committee objections, provide clarity, remove ambiguity, and implement technical changes. The changes will also allow reference to the General Statute. (Rules (10A NCAC 13B, .3801, .3903, .4103, .4104, and .5408).

Eight rules were revised without substantive changes (Rules 10A NCAC 13B .4106, .4305, .4603, .4801, .4805, .5102, .5105, .5406) and one rule is being repealed (Rule 10A NCAC 13B .5411). Per statute, these rules are not subject to a fiscal analysis therefore a discussion of these rules is not included in the document.

### Description of Proposed Rules and Anticipated Fiscal Impact

#### Rule 10A NCAC 13B .3801- Nurse Executive

The agency is proposing to readopt this rule with substantive changes. This rule establishes the criteria for the assignment of nursing staff for the provision of care according to a written plan. Changes clarify that the written plan is the plan of care that reflects the patient's goals and the nursing care to be provided to meet the patient's needs. The Nurse Executive must ensure that there are adequate numbers of clinical nursing personnel with the appropriate education, experience, licensure, competence, and specialized qualifications to provide nursing care for each patient in accordance with the individual needs of each patient specified in the plan of care. Adding this language will have no additional impact on the role of the Nurse Executive as this is a federal requirement under CMS regulations to receive federal funding and represents current practice. There is no fiscal impact associated with the amendment of this rule.

In addition, the agency referenced the General Statute for the practice of nursing services. Referencing the statute does not change or expand the scope of the nursing care services, it just clarifies the specific statutes that are applicable to the practice of nursing.

#### Rule 10A NCAC 13B .3903 - Preservation of Medical Records

The agency is proposing to amend this rule. This rule establishes the criteria for the preservation of medical records. Currently, the rule requires public notice to be given when a hospital is going to destroy medical records after the 11 year storage period in at least a written notice to the former patient or their representative and the display of an advertisement in a newspaper of general circulation in the area of the facility. The agency is updating the rule to not require patient notification before the destruction of the medical records. A review of other states' regulations in this space span from no regulations at all to a thirty year record retention policy.<sup>1</sup> In general, two other states have similar rules that require notification before destruction of medical records by hospitals (North Dakota and Pennsylvania) but most states do not require this notification. In addition to being in the minority of states with notification rules, requiring printed notice in the newspaper no longer makes sense as printed newspapers have dropped significantly in circulation and availability. Not requiring printed notice to either patients or their representatives and not requiring an advertisement to be printed in the newspaper will most likely save the hospital money.

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<sup>1</sup> Protecting Patient Information after a Facility Closure. Appendix C: States with Laws, Regulations, or Guidelines Pertaining to Facility Closure. Accessed 9/27/2021. <https://library.ahima.org/doc?oid=105007#.YUzI2zUpBhF>

The amount of money saved would be dependent upon the cost of the newspaper advertisement which differs between localities and also the number of patients they were required to notify in written form.

The loss of the notification requirement may increase the likelihood that a patient is unable to access their old medical records if they are not informed about the facility disposing of their records. However, it is unknown how many patients this rule change will impact as well as what the actual consequences of not being able to access medical records that are over a decade old would be. Overall, this rule change likely represents a cost savings to facilities.

#### Rule 10A NCAC 13B .4103 - Provision of Emergency Services

The agency is proposing to readopt this rule with substantive changes. This rule establishes the criteria for the provision of emergency services and requirements for interoperable communication. This rule is being changed to update the interoperable communication system to the North Carolina Voice Interoperability Plan for Emergency Responder (NC VIPER). All hospitals, with emergency departments, that receive patients from EMS, have access to the VIPER system. Each facility has been assigned an exclusive talk group (channel) to communicate with EMS units. All radios operating on the VIPER system are required to have the minimum statewide template installed. The template provides the facility with interoperability channels to communicate with public safety agencies and also the NC Emergency Management 24-hour Watch Center in the event of a disaster, terrorist event or total loss of traditional communications means (internet, telephone, cell phone).

The VIPER system is almost completely built out, and offers +95% statewide coverage, from the mobile level. The original VIPER radios were provided to all of the hospitals through a federal grant, passed through the Healthcare Preparedness Program (HPP) approximately 12-15 years ago. The radios became the property of the facility and it has been their responsibility for the maintenance and upgrades. The VIPER system is scheduled for a system upgrade to P25 phase II (TDMA) in 2025. The original radios are not capable of this upgrade and the facilities will need to replace them by that target date. OEMS has been pushing out information to the facilities since July 2019, on this required system upgrade. Many facilities have already completed the replacement of their VIPER units. The rule already requires operators to install, operate, and maintain their radios – this rule change simply updates the rule to reflect the current technology that is already being used by operators. There is no fiscal impact associated with the readoption of this rule.

Changes were also made to update language to current terminology, update reference to reflect rule recodification change, and included other technical changes.

#### Rule 10A NCAC 13B .4104 - Medical Director

The agency is proposing to readopt this rule with substantive changes. This rule establishes both the qualifications of the physician directing Level I, II, and III emergency services and the criteria for the duties and authority of the Medical Director/Director of Emergency Services. This rule is being updated to reflect a historical Rules Review Commission objection that determined the agency has no authority for regulating the qualifications of the director of emergency services.

The hospital's medical staff establishes the criteria for the qualifications for the director of the hospital's emergency services in accordance with State law and acceptable standards of practice. The qualifications include necessary education, experience, and specialized training. This is a federal requirement under CMS regulations to receive federal funding.

The proposed change removes the requirement for the director of emergency medical services to serve as chairman of the medical staff committee. The medical staff also establishes the criteria and delineates the qualifications a medical staff member must possess, in order to be granted privileges for the supervision of the provision of emergency care services and to serve as chairman of the medical staff committee. This is a federal requirement. There is no fiscal impact associated with the readoption of this rule.

#### Rule 10A NCAC 13B .5408 - Comprehensive Inpatient Rehabilitation Program Staffing Requirements

This rule establishes the inpatient rehabilitation program staffing requirements. The agency is proposing to readopt this rule with substantive changes. An historical Rules Review Commission Objection determined that the rule is confusing, and the agency lacked statutory authority to set staff qualification requirements. Revisions to the rule have satisfied this objection and technical changes were made. These rule changes should not result in any changes in practice and simply provide clarity to the rule's language.

There is no fiscal impact associated with the amendment of this rule.

#### Impact Summary

These readoptions update rules to account for current practices and language, remove ambiguity, address historical Rule Review Commission objections, and implement technical changes. Changes also allow reference to the General Statute where appropriate. The rule change that is likely to have the largest impact is Rule 10A NCAC 1B .3903 – Preservation of Medical Records. It will likely result in an unknown cost savings to the facility. The other rules are unlikely to have any fiscal impact.

## Appendix A

10A NCAC 13B .3801 is proposed for reoption with substantive changes as follows:

### SECTION .3800 - NURSING SERVICES

#### 10A NCAC 13B .3801 NURSE EXECUTIVE

- (a) Whether the facility utilizes a centralized or decentralized organizational structure, a nurse executive shall be responsible for the coordination of nursing organizational functions.
- (b) A nurse executive shall develop facility wide patient care programs, ~~policies~~ policies, and procedures that describe how the nursing care needs of patients are assessed, ~~met~~ met, and evaluated.
- (c) The nurse executive shall develop and adopt, subject to the approval of the facility, a set of administrative policies and procedures to establish a framework to accomplish required functions.
- (d) There shall be scheduled ~~meetings~~, meetings ~~at least~~ every 60 ~~days~~, days of the members of the nursing staff to evaluate the quality and efficiency of nursing services. Minutes of these meetings shall be maintained.
- (e) The nurse executive shall be responsible for:
  - (1) the development of a written organizational plan which describes the levels of accountability and responsibility within the nursing organization;
  - (2) identification of standards and policies and procedures related to the delivery of nursing care;
  - (3) planning for and the evaluation of the delivery of nursing care delivery system;
  - (4) establishment of a mechanism to validate qualifications, knowledge, and skills of nursing personnel;
  - (5) provision of orientation and educational opportunities related to expected nursing ~~performance~~, performance and maintenance of records pertaining thereto;
  - (6) implementation of a system for performance evaluation;
  - (7) provision of nursing care services in conformance with ~~the North Carolina Nursing Practice Act;~~ G.S. 90-171.20(7) and G.S. 90-171.20(8);
  - (8) assignment of nursing staff to clinical or managerial responsibilities based upon educational preparation, in conformance with licensing laws and an assessment of current competence; and
  - (9) staffing nursing units with ~~sufficient~~ personnel in accordance with a written ~~plan~~, plan of care to meet the needs of the patients.

*History Note: Authority G.S. 131E-75(b); 131E-79;  
Eff. January 1, ~~1996~~. 1996;  
Readopted Eff. July 1, 2022.*

10A NCAC 13B .3903 is proposed for readoption with substantive changes as follows:

**10A NCAC 13B .3903    PRESERVATION OF MEDICAL RECORDS**

- (a) The manager of medical records service shall maintain medical records, whether original, computer media, or microfilm, for ~~a minimum of~~ 11 years following the discharge of an adult patient.
- (b) The manager of medical records shall maintain medical records of a patient who is a minor until the patient's 30th birthday.
- (c) If a hospital discontinues operation, its management shall make known to the Division where its records are stored. Records shall be stored in a business offering retrieval services for ~~at least~~ 11 years after the closure date.
- ~~(d) The hospital shall give public notice prior to destruction of its records, to permit former patients or representatives of former patients to claim the record of the former patient. Public notice shall be in at least two forms: written notice to the former patient or their representative and display of an advertisement in a newspaper of general circulation in the area of the facility.~~
- ~~(e)~~ (d) The manager of medical records may authorize the microfilming of medical records. Microfilming may be done on or off the premises. If done off the premises, the facility shall provide for the confidentiality and safekeeping of the records. The original of microfilmed medical records shall not be destroyed until the medical records department has had an opportunity to review the processed film for content.
- ~~(f)~~ (e) Nothing in this Section shall be construed to prohibit the use of automation in the medical records service, provided that all of the provisions in this Rule are met and the information is readily available for use in patient care.
- ~~(g)~~ (f) Only personnel authorized by ~~state~~ State laws and Health Insurance Portability and Accountability Act (HIPAA) regulations shall have access to medical records. Where the written authorization of a patient is required for the release or disclosure of health information, the written authorization of the patient or authorized representative shall be maintained in the original record as authority for the release or disclosure.
- ~~(h)~~ (g) Medical records are the property of the hospital, and they shall not be removed from the facility jurisdiction except through a court order. Copies shall be made available for authorized purposes such as insurance claims and physician review.

*History Note:    Authority G.S. ~~90-21-20B~~; 131E-75(b); 131E-79; 131E-97;  
Eff. January 1, 1996;  
Amended Eff. July 1, ~~2009~~; 2009;  
Readopted Eff. July 1, 2022.*

10A NCAC 13B .4103 is proposed for readoption with substantive changes as follows:

**10A NCAC 13B .4103    PROVISION OF EMERGENCY SERVICES**

(a) Any ~~of any~~ facility providing emergency services shall establish and maintain policies requiring ~~appropriate~~ medical screening, treatment and transfer services for any individual who presents to the facility emergency department and on whose behalf treatment is requested regardless of that person's ability to pay for medical services and without delay to inquire about the individual's method of payment.

(b) Any facility providing emergency services under the rules of this Section shall install, ~~operate~~ operate, and maintain, on a 24-hour per day basis, an emergency two-way radio ~~licensed by the Federal Communications Commission in the Public Safety Radio Service~~ capable of ~~establishing~~ accessing the North Carolina Voice Interoperability Plan for Emergency Responders (VIPER) radio network for voice ~~radio~~ communication with ~~ambulance units~~ EMS providers transporting patients to ~~said~~ the facility or ~~having any written procedure or agreement for handling emergency services with the local ambulance service, rescue squad or other trained medical or provide on-line medical direction for EMS personnel.~~

(c) All communication equipment shall be in compliance with ~~current~~ the rules established by North Carolina Rules for ~~Basic Life Support/Ambulance Service (10 NCAC 3D .1100) adopted by reference with all subsequent amendments. Referenced rules are available at no charge from the Office of Emergency Medical Services, 2707 Mail Service Center, Raleigh, N.C. 27699-2707.~~ set forth in 10A NCAC 13P, Emergency Medical Services and Trauma Rules.

*History Note:* Authority G.S. 131E-75(b); 131E-79;  
Eff. January 1, 1996. 1996;  
Readopted Eff. July 1, 2022.

10A NCAC 13B .4104 is proposed for readoption with substantive changes as follows:

#### **10A NCAC 13B .4104 MEDICAL DIRECTOR**

(a) The governing body shall establish the qualifications, duties, and authority of the director of emergency services. Appointments shall be recommended by the medical staff and approved by the governing body.

(b) The medical staff credentials committee shall approve the mechanism for emergency privileges for physicians employed for brief periods of time such as evenings, ~~weekends~~ weekends, or holidays.

(c) Level I and II emergency services shall be directed and supervised by a ~~physician with experience in emergency care.~~ physician.

(d) Level III services shall be directed and supervised by a ~~physician with experience in emergency care or through a multi-disciplinary medical staff committee. The chairman of this committee shall serve as director of emergency medical services.~~ physician.

*History Note:* Authority G.S. 131E-75(b); 131E-79; 131E-85(a);  
RRC objection due to lack of statutory authority Eff. July 13, 1995;

*Eff. January 1, 1996. 1996.*

*Readopted Eff. July 1, 2022.*

10A NCAC 13B .4106 is proposed for readoption without substantive changes as follows:

#### **10A NCAC 13B .4106 POLICIES AND PROCEDURES**

Each emergency department shall establish written policies and procedures ~~which~~ that specify the scope and conduct of patient care to be provided in the emergency areas. They shall include the following:

- (1) the location, storage, and procurement of medications, blood, supplies, equipment and the procedures to be followed in the event of equipment failure;
- (2) the initial management of patients with burns, hand injuries, head injuries, fractures, multiple injuries, poisoning, animal bites, gunshot or stab ~~wounds~~ wounds, and other acute problems;
- (3) the provision of care to an unemancipated minor not accompanied by a parent or guardian, or to an unaccompanied unconscious patient;
- (4) management of alleged or suspected child, ~~elder~~ elder, or adult abuse;
- (5) the management of pediatric emergencies;
- (6) the initial management of patients with actual or suspected exposure to radiation;
- (7) management of alleged or suspected rape victims;
- (8) the reporting of individuals dead on arrival to the proper authorities;
- (9) the use of standing orders;
- (10) tetanus and rabies prevention or prophylaxis; and
- (11) the dispensing of medications in accordance with ~~state~~ State and federal laws.

*History Note: Authority G.S. 131E-75(b); 131E-79;*

*Eff. January 1, 1996. 1996.*

*Readopted Eff. July 1, 2022.*

10A NCAC 13B .4305 is proposed for readoption without substantive changes as follows:

#### **10A NCAC 13B .4305 ORGANIZATION OF NEONATAL SERVICES**

(a) The governing body shall approve the scope of all neonatal services and the facility shall classify its capability in providing a range of neonatal services using the following criteria:

- (1) LEVEL I: Full-term and pre-term neonates that are stable without complications. This may ~~include,~~ include infants who are small for gestational age or large for gestational age neonates.
- (2) LEVEL II: Neonates or infants that are stable without complications but require special care and frequent feedings; infants of any weight who no longer require Level III or LEVEL IV neonatal

services, but who still require more nursing hours than normal infant. This may include infants who require close observation in a licensed acute care ~~bed~~ bed.

- (3) LEVEL III: Neonates or infants that are high-risk, small (or approximately 32 and less than 36 completed weeks of gestational age) but otherwise healthy, or sick with a moderate degree of illness that are admitted from within the hospital or transferred from another facility requiring intermediate care services for sick infants, but not requiring intensive care. The beds in this level may serve as a "step-down" unit from Level IV. Level III neonates or infants require less constant nursing care, but care does not exclude respiratory support.
- (4) LEVEL IV (Neonatal Intensive Care Services): High-risk, medically unstable or critically ill neonates approximately under 32 weeks of gestational age, or infants, requiring constant nursing care or supervision ~~not limited to~~ that includes continuous cardiopulmonary or respiratory support, complicated surgical procedures, or other intensive supportive interventions.

(b) The facility shall provide for the availability of equipment, supplies, and clinical support services.

(c) The medical and nursing staff shall develop and approve policies and procedures for the provision of all neonatal services.

*History Note: Authority G.S. 131E-75(b); 131E-79;  
Eff. January 1, 1996;  
Temporary Amendment Eff. March 15, 2002;  
Amended Eff. April 1, ~~2003~~; 2003;  
Readopted Eff. July 1, 2022.*

10A NCAC 13B .4603 is proposed for readoption without substantive changes as follows:

#### **10A NCAC 13B .4603 SURGICAL AND ANESTHESIA STAFF**

~~(a)~~ The facility shall develop processes ~~which require that~~ that require each individual ~~provides~~ provide only those services for which proof of licensure and competency can be demonstrated. The facility shall require that:

~~(b) The facility shall require that:~~

- (1) when anesthesia is administered, a ~~qualified~~ physician is ~~immediately~~ available in the facility to provide care in the event of a medical emergency;
- (2) a roster of practitioners with a delineation of current surgical and anesthesia privileges is available and maintained for the service;
- (3) an on-call schedule of surgeons with privileges to be available at all times for emergency surgery and for post-operative clinical management is maintained;
- (4) the operating room is supervised by a ~~qualified~~ registered nurse or doctor of medicine or osteopathy;  
and

- (5) an operating room register which shall include date of the operation, name and patient identification number, names of surgeons and surgical assistants, name of anesthetists, type of anesthesia given, pre- and post-operative diagnosis, type and duration of surgical procedure, and the presence or absence of complications in surgery is maintained.

*History Note:* Authority G.S. 131E-75(b); 131E-79; 131E-85;  
Eff. January 1, 1996. 1996;  
Readopted Eff. July 1, 2022.

10A NCAC 13B .4801 is proposed for readoption without substantive changes as follows:

### SECTION .4800 - DIAGNOSTIC IMAGING

#### 10A NCAC 13B .4801 ORGANIZATION

- (a) Imaging services shall be under the supervision of a full-time radiologist, consulting radiologist, or a ~~physician~~ physician. ~~experienced in the particular imaging modality and the~~ The physician in charge must shall have the credentials required by facility policies.
- (b) ~~Activities of the imaging service may include radio therapy.~~ Radio-therapy is a type of imaging service.
- (c) All imaging equipment shall be operated under professional supervision by ~~qualified~~ personnel trained in the use of imaging equipment and knowledgeable of all applicable safety precautions required by the North Carolina Department of ~~Environment and Natural Resources, Health and Human Services, Division of Environmental Health Service Regulation, Radiation Protection Section.~~ Section set forth in 10A NCAC 15, hereby incorporated by reference including subsequent amendments. ~~Copies of regulations are available from the N.C. Department of Environment and Natural Resources, Radiation Protection Section, 3825 Barrett Drive, Raleigh, NC 27609 at a cost of sixteen dollars (\$16.00) each.~~

*History Note:* Authority G.S. 131E-75(b); 131E-79;  
RRC objection due to lack of statutory authority and ambiguity Eff. July 13, 1995;  
Eff. January 1, 1996. 1996;  
Readopted Eff. July 1, 2022.

10A NCAC 13B .4805 is proposed for readoption without substantive changes as follows:

#### 10A NCAC 13B .4805 SAFETY

- (a) The facility shall require that all imaging equipment is operated under the supervision of a physician and by qualified personnel.
- (b) The facility shall require that proper caution is exercised to protect all persons from exposure to radiation.
- (c) Safety inspections of the imaging department, including equipment, shall be conducted by the North Carolina Division of ~~Environmental Health, Health Service Regulation, Radiation Protection Services~~ Section. Copies of the report shall be available for review by the Division.
- (d) The governing authority shall appoint a radiation safety committee. The committee shall ~~include but is not limited to:~~ include:
- (1) a physician experienced in the handling of radio-active isotopes and their therapeutic use; and
  - (2) other representatives of the medical staff.
- (e) All radio-active isotopes, whether for diagnostic, therapeutic, or research purposes shall be received, handled, and disposed of in accordance with the requirements of the North Carolina Department of ~~Environment and Natural Resources, Health and Human Services, Division of Environmental Health, Health Service Regulation, Radiation Protection Services~~ Section. Section set forth in 10A NCAC 15, hereby incorporated by reference including subsequent amendments. ~~Copies of regulations are available from the North Carolina Department of Environment, Health, and Natural Resources, Division of Radiation Protection, 3825 Barrett Drive, Raleigh, NC 27609 at a cost of six dollars (\$6.00) each.~~

*History Note: Authority G.S. 131E-75(b); 131E-79;  
Eff. January 1, ~~1996~~. 1996;  
Readopted Eff. July 1, 2022.*

10A NCAC 13B .5102 is proposed for readoption without substantive changes as follows:

#### **10A NCAC 13B .5102 POLICY AND PROCEDURES**

- (a) Each facility department or service shall establish and maintain written infection control policies and procedures. These shall ~~include but are not limited to:~~ include:
- (1) the role and scope of the service or department in the infection control program;
  - (2) the role and scope of surveillance activities in the infection control program;
  - (3) the methodology used to collect and analyze data, maintain a surveillance program on nosocomial infection, and the control and prevention of infection;
  - (4) the specific precautions to be used to prevent the transmission of infection and isolation methods to be utilized;
  - (5) the method of sterilization and storage of equipment and supplies, including the reprocessing of disposable items;
  - (6) the cleaning of patient care areas and equipment;

- (7) the cleaning of non-patient care areas; and
- (8) exposure control plans.

(b) The infection control committee shall approve all infection control policies and procedures. The committee shall review all policies and procedures ~~at least~~ every three years and indicate the last date of review.

(c) The infection control committee shall meet ~~at least~~ quarterly and maintain minutes of meetings.

*History Note: Authority G.S. 131E-75(b); 131E-79;  
Eff. January 1, ~~1996~~. 1996;  
Readopted Eff. July 1, 2022.*

10A NCAC 13B .5105 is proposed for readoption without substantive changes as follows:

#### **10A NCAC 13B .5105 STERILE SUPPLY SERVICES**

The facility shall provide for the following:

- (1) decontamination and sterilization of equipment and supplies;
- (2) monitoring of sterilizing equipment on a routine schedule;
- (3) establishment of policies and procedures for the use of disposable items; and
- (4) establishment of policies and procedures addressing shelf life of stored sterile items.

*History Note: Authority G.S. 131E-75(b); 131E-79;  
Eff. January 1, ~~1996~~. 1996;  
Readopted Eff. July 1, 2022.*

10A NCAC 13B .5406 is proposed for readoption without substantive changes as follows:

#### **10A NCAC 13B .5406 DISCHARGE CRITERIA FOR INPATIENT REHABILITATION FACILITIES OR UNITS**

(a) Discharge planning shall be an integral part of the patient's treatment plan and shall begin upon admission to the facility. After established goals have been reached, or a determination has been made that care in a less intensive setting would be appropriate, or that further progress is unlikely, the patient shall be discharged to an appropriate setting. Other reasons for discharge may include an inability or unwillingness of patient or family to cooperate with the planned therapeutic program or medical complications that preclude a further intensive rehabilitative effort. The facility shall involve the patient, family, staff ~~members~~ members, and referral sources in discharge planning.

(b) The case manager shall facilitate the discharge or transfer process in coordination with the facility social worker.

(c) If a patient is being referred to another facility for further care, ~~appropriate~~ documentation of the patient's current status shall be forwarded with the patient. A ~~formal~~ discharge summary shall be forwarded within 48 hours following discharge and shall include the reasons for referral, the diagnosis, functional limitations, services provided, the results of services, referral action ~~recommendations~~ recommendations, and activities and procedures used by the patient to maintain and improve functioning.

*History Note: Authority G.S. 131E-75(b); 131E-79;  
Eff. March 1, ~~1996~~. 1996;  
Readopted Eff. July 1, 2022.*

10A NCAC 13B .5408 is proposed for readoption with substantive changes as follows:

**10A NCAC 13B .5408      COMPREHENSIVE INPATIENT REHABILITATION PROGRAM STAFFING  
REQUIREMENTS**

(a) The staff of the inpatient rehabilitation facility or unit shall ~~include at a minimum~~ include:

- (1) the inpatient rehabilitation facility or unit shall be supervised by a rehabilitation ~~nurse~~. nurse as defined in Rule .5401 of this Section. The facility shall ~~identify the nursing skills necessary to meet the needs of the rehabilitation patients in the unit and~~ assign staff qualified to meet those needs;
- (2) the minimum nursing hours per patient in the rehabilitation unit shall be 5.5 nursing hours per patient day. At no time shall direct care nursing staff be less than two full-time equivalents, one of which must be a registered nurse;
- (3) the inpatient rehabilitation unit shall employ or provide by contractual agreements ~~sufficient~~ therapist to provide ~~a minimum of~~ three hours of specific (physical, occupational or speech) or combined rehabilitation therapy services per patient day;
- (4) physical therapy assistants and occupational therapy assistants shall be supervised on-site by physical therapists or occupational therapists;
- (5) rehabilitation aides shall have documented training appropriate to the activities to be performed and the occupational licensure laws of his or her supervisor. The overall responsibility for the on-going supervision and evaluation of the rehabilitation aide remains with the registered nurse as identified in Subparagraph (a)(1) of this Rule. Supervision by the physical therapist or by the occupational therapist is limited to that time when the therapist is on-site and directing the rehabilitation activities of the aide; and
- (6) hours of service by the rehabilitation aide are counted toward the required nursing hours when the aide is working under the supervision of the nurse. Hours of service by the rehabilitation aide are counted toward therapy hours during that time the aide works under the immediate, on-site supervision of the physical therapist or occupational therapist. Hours of service shall not be dually

counted for both services. Hours of service by rehabilitation aides in performing nurse-aide duties in areas of the facility other than the rehabilitation unit shall not be counted toward the 5.5 hour minimum nursing requirement described for the rehabilitation unit.

(b) Additional personnel shall be provided as required to meet the needs of the patient, as defined in the comprehensive inpatient rehabilitation evaluation.

*History Note:* Authority G.S. 131E-75(b);131E-79;  
RRC Objection due to lack of statutory authority Eff. January 18, 1996;  
Eff. May 1, ~~1996~~. 1996;  
Readopted Eff. July 1, 2022.

10A NCAC 13B .5411 is proposed for readoption as a repeal as follows:

**10A NCAC 13B .5411 PHYSICAL FACILITY REQUIREMENTS/INPATIENT REHABILITATION FACILITIES OR UNIT**

*History Note:* Authority G.S. 131E-79;  
Eff. March 1, ~~1996~~. 1996;  
Repealed Eff. January 1, 2022.