Title 10 MARYLAND DEPARTMENT OF HEALTH

Subtitle 07 HOSPITALS

Chapter 02 Nursing Homes

Authority: Health-General Article, §§19-308, 19-308.1, 19-323, and 19-1401 et seq.; Public Safety Article, §14-110.1; Annotated Code of Maryland

.01 Definitions.

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

B. Terms Defined.

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

(2) "Attending physician" means an individual licensed to practice medicine in the State who:

(a) Admits residents to the nursing home; and

(b) Is responsible for the overall care of a resident.

(3) "Audiologist" means an individual who holds a Maryland license issued by the State Board of Audiologists, Hearing Aid Dealers, and Speech-Language Pathologists.

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

(5) "Certified medicine aide" means an individual who meets the requirements as stated in COMAR 10.39.01 and 10.39.03.

(6) "Certified social worker" means an individual licensed to practice as a certified social worker in this State.

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

(8) "Chemical restraint" means the administration of any drug that is used for discipline or convenience and not required to treat medical symptoms.

(9) "Comprehensive care facility" means a nursing home that admits residents requiring medical services and nursing services rendered by or under the supervision of a registered nurse, who:

(a) Are advanced in age; or

(b) Have a disease or a disability.

(10) "Concurrent review" means daily rounds by a licensed nurse which include:

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

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

(i) Hydration and nutritional needs;

(ii) Skin integrity;

(iii) Noted weight changes; and

(iv) Appetite;

(c) Evaluation of injuries sustained by the resident that result from an accident or incident involving the resident; and

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

(11) "Culture change facility" means a nursing home where physical environment and operational changes have been made to establish person-valued and person-directed care activities and services.

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

(13) "Dentist" means an individual licensed to practice dentistry in this State.

(14) "Department" means the Maryland Department of Health.

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

(a) Is a qualified dietitian;

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

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

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

(e) Has training and experience in food service supervision and management in a military service equivalent in content to §B(15)(b) and (d) of this regulation.

(16) "Dietitian-nutritionist" means an individual who:

(a) Is licensed by the Maryland Board of Dietetic Practice to practice dietetics;

(b) Has met the certifying requirements for registration as a dietitian as administered by the Commission on Dietetic Registration; and

(c) Maintains the continuing education requirements of registration.

(17) "Discharge" means the removal of a resident from a nursing home when the releasing nursing home is no longer responsible for the resident's care.

(18) "Discipline" means the medical, rehabilitative, nursing, dietetic, activities and social service components affiliated with the operation of a nursing home.

(19) "Distinct part extended care facility" means a portion of a nursing home that is licensed as an extended care facility.

(20) "Extended care facility" means a nursing home that offers sub-acute care and provides medical treatment services for residents who require inpatient care but who do not currently require continuous hospital services.

(21) "Facility" means a nursing home.

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

(23) "Full time" means 40 hours per week or the standard work week adopted by the nursing home.

(24) "Geriatric nursing assistant" means a CNA who has successfully completed the requirements for a GNA set forth in 42 CFR §§483.151—483.156 and COMAR 10.39.01.

(25) "Grant" means the award of money to an individual or an organization to:

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

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

(26) "Health officer" means the health officer or the designated representative in each of the 23 counties and the Commissioner of Health in Baltimore City.

(27) "HVAC" means heating, ventilation and air conditioning.

(28) "Infection preventionist" means a licensed healthcare worker who:

(a) Manages the infection prevention and control program in the nursing home; and

(b) Has completed a minimum of 15 contact hours of infection prevention and control training that is approved by the:

(i) Department's Office of Infectious Disease Epidemiology and Outbreak Response; and

(ii) Office of Health Care Quality.

(29) "Licensed bachelor social worker (LBSW)" means an individual authorized to practice bachelor social work under Health Occupations Article, Title 19, Annotated Code of Maryland.

(30) "Licensed certified social worker (LCSW)" means an individual authorized to practice certified social work under Health Occupations Article, Title 19, Annotated Code of Maryland.

(31) "Licensed certified social worker–clinical (LCSW-C)" means an individual authorized to practice clinical social work under Health Occupations Article, Title 19, Annotated Code of Maryland.

(32) "Licensed master social worker" means an individual authorized to practice master social work under Health Occupations Article, Title 19, Annotated Code of Maryland.

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

(34) "Licensed pharmacist" means an individual who is licensed by the Board to practice pharmacy as defined in Health Occupations Article, §12-101(l), Annotated Code of Maryland.

(35) "Licensed practical nurse" means an individual authorized to practice licensed practical nursing under Health Occupations Article, Title 8, Annotated Code of Maryland.

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

(37) "MDS Care Area Assessment" means the investigation of triggered care areas, to determine if the care area or areas require interventions and care planning.

(38) "Medical director" means an individual licensed to practice medicine in this State who, pursuant to a written agreement, is responsible for the overall coordination of the medical care in the nursing home to ensure the adequacy and appropriateness of the medical services provided to residents and to maintain surveillance of the health status of employees.

(39) "Minimum Data Set (MDS)" means a core set of screening, clinical, and functional status elements, including common definitions and coding categories, which:

(a) Forms the foundation of a comprehensive assessment for all nursing home and swing bed residents; and

(b) Standardize communication about resident problems and conditions:

(i) Within these facilities;

(ii) Between these facilities; and

(iii) Between these facilities and outside agencies.

(40) "New nursing home" means a nursing home that does not yet have plans approved by the Department at the time of the adoption of this chapter.

(41) "NFPA" means National Fire Protection Association.

(42) "Nurse" means a licensed practical nurse or registered nurse licensed in the State as defined in Health Occupations Article, §8-101, Annotated Code of Maryland.

(43) "Nurse practitioner" has the meaning stated in Health Occupations Article, §8-101(k), Annotated Code of Maryland.

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

(45) "Nursing home" means a comprehensive care facility or extended care facility which offers nonacute inpatient care to residents:

(a) Who have a disease, chronic illness, condition, disability of advanced age, or terminal disease requiring maximal nursing care without continuous hospital services; and

(b) Who require medical services and nursing services rendered by or under the supervision of a licensed nurse together with convalescent, restorative, or rehabilitative services.

(46) "Nursing service personnel" means staff licensed or certified by the Maryland Board of Nursing.

(47) "Occupational therapist" means an individual who is licensed by the State Board of Occupational Therapy Practice to practice occupational therapy.

(48) "Occupational therapy assistant" means an individual who is currently licensed by the State Board of Occupational Therapy Practice as an occupational therapy assistant.

(49) "Ongoing pattern" means the occurrence of any potential for more than minimal harm or greater deficiency on two consecutive on-site visits as a result of:

(a) Annual surveys;

(b) Follow-up visits and unscheduled visits; or

(c) Complaint investigations.

(50) "Paid feeding assistant" means an individual who:

(a) Meets the requirements of Regulation .63 of this chapter; and

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

(51) "Physical restraint" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body including but not limited to:

(a) Leg restraints;

(b) Arm restraints;

(c) Hand mitts;

(d) Soft ties or vests;

(e) Lap cushions; and

(f) Lap trays.

(52) "Physical therapist" means an individual licensed to practice physical therapy by the State Board of Physical Therapy Examiners.

(53) "Physician" means an individual licensed to practice medicine in this State.

(54) "Physician assistant" has the meaning stated in Health Occupations Article, §15-101(o), Annotated Code of Maryland.

(55) "Plan of correction" means a written response from the nursing home addressing each deficiency cited as a result of an inspection by the Department.

(56) "Positive tuberculin skin test" means a test provided as authorized by the Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings.

(57) "Principal physician" means an individual licensed to practice medicine in this State who agrees to perform certain medical services under contract with a nursing home, consistent with the policies of the nursing home.

(58) "Protective device" means any device or equipment:

(a) That is prescribed by a physician;

(b) That limits, but does not eliminate the movement of the resident's head, body, or limbs; and

(c) That:

(i) Shields a resident from self-injury;

(ii) Prevents a resident from aggravating an existing physical problem; or

(iii) Prevents a resident from precipitating a potential physical problem.

(59) "Qualified medical record practitioner" means an individual who:

(a) Has:

(i) Received a baccalaureate degree from an accredited college or university including or supplemented by a successful completion of a course in health record administration approved by the Council on Medical Education of the American Medical Association; and

(ii) Passed the national registration examination for registered record administrators; or

(b) Has:

(i) Received an associate of arts degree in health record technology from a college or university approved by the American Medical Association Council on Medical Education or an equivalent approved health record technology correspondence course of the American Medical Record Association; and

(ii) Passed the national accreditation examination for accredited record technicians.

(60) "Qualified social work consultant" means an individual who:

(a) Is a licensed certified social worker; and

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

(61) "Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system" means the standard nationwide system to which several types of health care providers submit CMS required resident information to the National Submissions Database.

(62) "Registered nurse" means an individual licensed to practice as a registered nurse in this State.

(63) Relocation.

(a) "Relocation" means the movement of a resident from one room to another within:

(i) The same Medicare-certified nursing home;

(ii) A Medicaid-only certified nursing home; or

(iii) A licensed-only nursing home.

(b) "Relocation" does not mean the movement of a resident if the effect of the movement is to move the resident from:

(i) The distinct part of the nursing home that is a skilled nursing facility to a distinct part of the nursing home that is not a skilled nursing facility; or

(ii) A bed that is certified for Medicaid to a distinct part of the nursing home that is a skilled nursing facility.

(64) "Resident" means an individual who:

(a) Resides in the nursing home; and

(b) Receives nursing services rendered by or under the supervision of a registered nurse.

(65) "Resident activities coordinator" means an individual who:

(a) Is a:

(i) Certified therapeutic recreation specialist;

(ii) Licensed occupational therapist; or

(iii) Licensed occupational therapy assistant; or

(b) Has 2 years of experience in a social or recreational program in a licensed health care setting within the last 5 years, 1 year of which was full time in a resident activities program with guidance from an individual identified in §B(73)(a) of this regulation.

(66) Resident Assessment Instrument (RAI).

(a) "Resident Assessment Instrument (RAI)" means a standardized and reproducible resident assessment process based on completion of Minimum Data Set (MDS) screening items, and including the MDS Care Area Assessment process, and related process for care planning and evaluation.

(b) "Resident Assessment Instrument (RAI)" includes:

(i) Minimum Data Set;

(ii) MDS Care Area Assessment Process; and

(iii) RAI utilization guidelines.

(67) "Resident's representative" means a person with the authority to act on the resident's behalf regarding the matter at issue.

(68) "Restraint" means any physical or chemical restraint as defined in this chapter.

(69) "Secretary" means the Secretary of Health.

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

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

(72) "Speech-language pathologist" means an individual licensed by the State Board of Audiologists, Hearing Aid Dispensers, and Speech-Language Pathologists.

(73) "Support personnel" means an aide who:

(a) Is assigned to a particular service such as:

(i) Nursing;

(ii) Dietary;

(iii) Physical therapy; or

(iv) Occupational therapy; and

(b) Has been approved by the manager of the services as having sufficient training and experience to perform the assigned duties.

(74) "Tuberculin skin test" means a test to diagnose tuberculosis infection using purified protein derivative (PPD) that is injected intradermally and read within 48—72 hours with results recorded in millimeters of induration.

(75) Tuberculosis in a Communicable Form.

(a) "Tuberculosis in a communicable form" means that an individual:

(i) Is presumed to have active pulmonary or laryngeal tuberculosis as evidenced by positive X-ray findings with or without positive acid-fast bacilli (AFB) sputum smear or positive AFB sputum culture; and

(ii) Has received chemotherapy for less than 14 days.

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

(i) When the individual who has presumptive or confirmed active disease, has had three negative AFB smears, collected 8—24 hours apart, shows clinical improvement, and has received chemotherapy to which the strain is susceptible for at least 14 days; or

(ii) The individual who has inactive pulmonary scarring, calcification, or a normal chest X-ray.

(76) "Two-step tuberculin skin testing" means the administration of a second tuberculin skin test 1 to 3 weeks after the initial skin test is negative, to identify individuals with a past TB infection who may now have reduced skin reactivity.

.02 Incorporation by Reference.

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

B. Documents Incorporated.

(1) CMS Long-term Care Facility Resident Assessment Instrument 3.0 User's Manual, (Version 1.14, October 2016).

(2) CMS Manual System, Pub. 100-07 State Operations Provider Certification, (Transmittal 127, November 26, 2014, U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services).

(3) Guidelines for Design and Construction of Residential Health, Care, and Support Facilities. (2014) Facility Guidelines Institute, which is incorporated in COMAR 10.07.01.02.

(4) 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (Centers for Disease Control and Prevention (CDC), Healthcare Infection Control Practices Advisory Committee (HIPAC), 2007).

(5) Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005 (MMWR2005; 54, No. RR-17, Centers for Disease Control and Prevention (CDC), Atlanta, GA).

(6) Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP), (MMWR2011; 60 No. SS-07, Centers for Disease Control and Prevention (CDC), Atlanta, GA).

(7) National Fire Protection Association, NFPA 99 Health Care Facilities Code (2015 Edition).

(8) National Fire Protection Association, NFPA 101 "Life Safety Code", which is incorporated by reference at COMAR 29.06.01.06.

(9) Recommended Dietary Allowances, (10th Edition, Food and Nutritional Board, Commission on Life Sciences, and National Research Council, 1989).

.03 License Required.

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

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

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

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

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

(a) Its application for initial license or license renewal; or

(b) A notice describing where in the facility the application for licensure or relicensure may be found.

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

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

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

F. Provisional License.

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

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

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

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

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

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

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

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

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

H. Plan of Correction Required.

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

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

.04 Licensing Procedure.

A. Application for License.

(1) An applicant desiring to open a comprehensive care facility or an extended care facility shall file an application with the Secretary, on a written or electronic form provided by the Secretary.

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

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

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

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

(a) Ownership of real property;

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

(c) Ownership of equipment; and

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

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

(7) Additional Requirements.

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

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

(ii) Ability to comply with the applicable standards of medical and nursing care and applicable State or federal laws and regulations by disclosing the identities of its medical director, director of nursing, and administrator, and by providing the nursing home's quality assurance plan, as required in Regulation .66 of this chapter; and

(iii) Financial and administrative ability to maintain a nursing home in compliance with these regulations, including submission of an audited financial statement, whether or not the applicant ever operated a nursing home, related institution, or other health care facility.

(b) The Secretary shall:

(i) Approve the application unconditionally;

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

(iii) Deny the application.

(c) A person who disagrees with the decision of the Secretary to deny a license application under this section may appeal the Secretary's action by filing a request for a hearing in accordance with Regulation .78 of this chapter.

B. Restrictions of License.

(1) Nomenclature. A nursing home licensed under this regulation may not use the word "hospital" in its title.

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

(3) Local Law or Ordinance, Where Applicable. A nursing home located in a political subdivision which requires it to meet certain standards shall submit proof to the Secretary that the nursing home meets local laws, regulations, or ordinances at the time application for license is submitted.

(4) Transfer or Assignment of License.

(a) If the sale, transfer, assignment, or lease of a nursing home causes a change in the person or persons who control or operate the nursing home, the nursing home shall be considered a "new nursing home" and the licensee shall conform to all regulations applicable at the time of transfer of operations.

(b) The transfer of any stock which results in a change of the person or persons who control the nursing home, or a 25 percent or greater change in any form of ownership interest, constitutes a sale.

(c) For purposes of Life Safety Code enforcement, the nursing home is considered to be an existing nursing home if it has been in continuous use as a nursing home. Waivers may be granted under Regulation .03F of this chapter.

(5) Return of License to the Secretary of Health. The current license shall immediately become void and shall be returned to the Secretary if the:

(a) Nursing home is sold, leased, or discontinued;

(b) Operation moved to a new location; or

(c) License is revoked.

.05 Licensed Bed Capacity.

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

(1) Requests that the facility exceed its licensed bed capacity; or

(2) Approves a request from a facility to exceed its licensed bed capacity.

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

(1) Circumstances that prompted the Department to make the request;

(2) Conditions under which the licensed bed capacity may be exceeded; and

(3) Number of residents by which the facility's licensed capacity may be exceeded.

C. Request for Departmental Permission to Exceed Capacity.

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

(2) The written request shall include the:

(a) Circumstances or reasons for the request;

(b) Identity of any resident involved;

(c) Beginning and ending dates for which the request is made; and

(d) Documentation of any objection by a resident affected by the request, or by the resident's personal representative.

(3) The nursing home shall:

(a) Submit the written request to the Office of Licensing and Certification Programs; and

(b) Make the request for a term not to exceed 30 days.

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

(a) Needs of the resident whose admission is proposed;

(b) Ability of the facility to care for the resident properly;

(c) Likely effect of the admission on the comfort and care of the other residents in the facility; and

(d) Evidence that exceeding licensed capacity would help resolve the emergency situation.

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

(a) Provide the following equipment for the exclusive use of the resident:

(i) Electronic nurses call system or hand bell,

(ii) Privacy curtain or screen,

(iii) Storage space for belongings, and

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

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

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

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

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

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

.06 Rights of Applicant if License Denied or Revoked.

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

B. Revocation of License.

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

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

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

(c) The compliance history of the facility; and

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

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

.07 Inspection by Secretary.

A. Open at all Times for Inspection. Licensed nursing homes and any premises that an applicant for a license proposes to operate shall be open at all times to inspection by the Secretary and by any agency designated by the Secretary.

B. Site Visits and Surveys.

(1) The Department shall make a site visit and conduct a full survey of each licensed nursing home at least once per calendar year.

(2) All surveys shall be unannounced.

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

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

E. The Department shall make a site visit and conduct a full survey of each licensed nursing home at least once per calendar year.

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

A. Submission of Plans.

(1) The architect or professional engineer of record shall submit stamped and sealed final construction drawings to the Department.

(2) The architect or professional engineer of record shall submit a letter certifying that the project has been designed in accordance with all applicable federal, State, and local codes, laws, ordinances, and regulations for construction.

B. Plan Approval.

(1) A system of water supply, plumbing, sewerage, electrical power, garbage or refuse disposal may not be installed or extended until the architect or professional engineer of record submits stamped and sealed final construction drawings for Department record and provisional approval in accordance with §A of this regulation.

(2) The architect or professional engineer of record shall also submit a letter certifying that the project has been designed in accordance with all applicable federal, State, and local codes, laws, ordinances, and regulations.

C. New Construction.

(1) A new nursing home shall satisfy the review of the Maryland Health Care Commission for the:

(a) Establishment of a new nursing home; and

(b) Increase or decrease in capacity of an existing nursing home.

(2) After obtaining approval by the Maryland Health Care Commission, the nursing home shall provide written verification of the approval to the Office of Health Care Quality.

(3) Verification shall include:

(a) Details of the proposed nursing home changes; and

(b) Written plans that describe how all residents, staff, and the general public will be kept safe for the duration of the project.

D. Conversion, Alteration, and Additions.

(1) An existing nursing home that wishes to convert, alter, modify, or add to the existing infrastructure shall notify the Office of Health Care Quality in writing.

(2) The nursing home shall provide the Office of Health Care Quality with the documentation that verifies that the applicable local and State governmental authorities have approved work that was done.

(3) The nursing home shall provide additional information upon request.

.09 Administration and Resident Care.

A. Responsibility.

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

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

B. Delegation to Administrator.

(1) The licensee, if not acting as an administrator, shall appoint as administrator a responsible person who is:

(a) Qualified by training and experience; and

(b) Licensed by the Board of Examiners of Nursing Home Administrators for the State.

(2) The administrator shall:

(a) Be responsible for the control of the operation on a 24-hour basis; and

(b) With the exception of §B(3) of this regulation, serve full-time.

(3) With the Department's approval, an administrator may serve on a less than full-time basis for a maximum of two nursing facilities, one of which shall have a licensed capacity of 35 beds or fewer.

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

(a) Geographic location of the facilities;

(b) Ownership of the facilities;

(c) Organizational structure of the facilities;

(d) Size of the facilities; and

(e) Background and experience of the administrator.

C. Absence of Administrator.

(1) In the absence of the administrator, the nursing home at all times shall be under the direct and personal supervision of an experienced, trained, competent employee.

(2) When serving as relief for the administrator, the director of nursing shall designate an experienced, qualified registered nurse to direct the nursing service.

(3) The relief director of nursing shall be freed from other responsibilities.

D. Excessive Absenteeism of Administrator.

(1) If the director of nursing's absence while covering for the administrator is having an adverse effect on resident care, the Department may require the designation of a specific registered nurse who shall be named the assistant director of nursing.

(2) The Department shall be notified of the name of the assistant director of nursing.

(3) When the designee is replaced, the Department shall be notified of the name of the registered nurse filling the vacancy.

E. Character. The administrator shall:

(1) Be of good moral character;

(2) Be in good physical and mental health; and

(3) Demonstrate a genuine interest in the well-being and welfare of residents in the nursing home.

F. Staffing.

(1) The administrator shall employ sufficient and satisfactory personnel as specified in this chapter to:

(a) Provide maintenance, cleaning, and housekeeping;

(b) Assist residents with eating; and

(c) Give adequate resident care.

(2) Voluntary Admissions Ceiling.

(a) A nursing home may request a voluntary admissions ceiling by submitting a written request to the Department to authorize a temporary restriction on resident admissions based upon anticipated bed usage.

(b) When the nursing home wishes to request that the restriction be removed, the request shall include the specific effective date and a statement that personnel staffing is sufficient to meet the State's requirements at the designated census level.

(c) The Department shall approve the increase in beds within 72 hours following receipt of the nursing home's documentation that the required additional staff is in position to serve the increased number of beds.

(d) Management of the nursing home may not permit the resident census to exceed the admissions ceiling without prior approval from the Department.

G. Educational Program.

(1) The administrator shall plan an ongoing educational program to develop and improve the skills of all the nursing home's personnel, including training related to problems and needs of the aged, ill, and disabled.

(2) The administrator shall maintain records reflecting attendance, by name and title, and training content.

(3) In-service training shall include at least:

(a) Prevention and control of infections;

(b) Fire prevention programs and resident related safety procedures in emergency situations or conditions;

(c) Accident prevention;

(d) Confidentiality of resident information;

(e) Preservation of resident dignity, including protection of the resident's privacy and personal and property rights;

(f) Physical, functional, and psychosocial needs of the aged ill individuals;

(g) Receipt by each employee of appropriate orientation to the facility and its policies, and to the employee's position and duties;

(h) Approval by the Department of the orientation and training programs.

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

(1) Employee's Social Security number;

(2) Home address;

(3) Educational background;

(4) Past employment documentation with references;

(5) Past nursing home employment documentation, including any past instances of abuse of residents, theft, and fires;

(6) Verified licensure of personnel employed; and

(7) Proof of criminal background check.

I. Support Personnel.

(1) To support placement in a specific position, there shall be sufficient documentation in the employee's record reflecting training and experience.

(2) In instances when an aide is to be assigned to a particular service such as dietary, physical therapy, or occupational therapy, the person in charge of the service shall be responsible for evaluating and approving or disapproving the qualifications.

J. New Support Personnel.

(1) New support personnel shall be credited for 50 percent of their working time until the employee's orientation program, as approved by the Department, is completed.

(2) Employee Orientation Program.

(a) New support personnel shall have an employee orientation program.

(b) The person in charge of the service to which the employee is assigned shall:

(i) Have input into the contents of the orientation program;

(ii) Determine the number of hours of orientation required for the various levels of support personnel; and

(iii) Following the period of orientation, indicate whether the employee satisfactorily completed the orientation program.

(3) The responsible department's approval shall be in writing, signed by the appropriate department head whose license number, if applicable, shall be recorded in the record.

(4) In new facilities, the director of nursing and supervisors of dietary services, housekeeping, rehabilitation services, and social services shall be responsible for orienting the new support personnel to the nursing home policies and procedures and to the physical plant.

(5) There shall be a complete orientation for all the employees in life safety and disaster preparedness.

(6) The number of daily admissions of residents shall be controlled to allow sufficient time for on-the-job training.

(7) Before the opening of the nursing home, support personnel shall have a minimum of 2 days of orientation training.

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

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

M. Except where inappropriate for safety reasons, an employee and any other individual who provides a health care service within or on the premises of the nursing home shall wear a personal identification tag that:

(1) States the name of the individual;

(2) States the profession or other title of the individual; and

(3) Is in a readily visible type font and size.

.10 Employee Training on Cognitive Impairment and Mental Illness.

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

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

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

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

(1) An overview of the following:

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

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

(c) Risk factors for cognitive impairment;

(d) Risk factors for mental illness;

(e) Health conditions that affect cognitive impairment;

(f) Health conditions that affect mental illness;

(g) Early identification and intervention for cognitive impairment;

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

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

(2) Effective communication including:

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

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

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

(d) Environmental stimuli and influences on communication;

(3) Behavioral interventions including:

(a) Identifying and interpreting behavioral symptoms;

(b) Problem solving for appropriate intervention;

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

(d) De-escalation techniques;

(4) Making activities meaningful including:

(a) Understanding the therapeutic role of activities;

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

(c) Structuring the day;

(5) Staff and family interaction including:

(a) Building a partnership for goal-directed care;

(b) Understanding families' needs; and

(c) Effective communication between family and staff;

(6) End-of-life care including:

(a) Pain management;

(b) Providing comfort and dignity; and

(c) Supporting the family; and

(7) Managing staff stress including:

(a) Understanding the impact of stress on job performance, staff relations, and overall facility environment;

(b) Identification of stress triggers;

(c) Self-care skills;

(d) De-escalation techniques; and

(e) Devising support systems and action plans.

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

(1) An overview of the following:

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

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

(c) Risk factors for cognitive impairment;

(d) Risk factors for mental illness;

(e) Health conditions that affect cognitive impairment;

(f) Health conditions that affect mental illness;

(g) Early identification and intervention for cognitive impairment;

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

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

(2) Effective communication including:

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

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

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

(d) Environmental stimuli and influences on communication; and

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

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

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

(2) 1 hour for all other employees.

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

(1) Classroom instruction;

(2) In-service training;

(3) Internet courses;

(4) Correspondence courses;

(5) Pre-recorded training; or

(6) Other training methods.

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

.11 Admission and Discharge.

A. Written Policy. The nursing home shall develop written policies, consistent with this chapter and COMAR 10.07.09, to govern the nursing care, related medical, and other services that the nursing home provides regarding:

(1) Admissions, transfers, and discharges;

(2) Acceptable payment sources; and

(3) Medical Assistance program information.

B. The nursing home shall make its admission and discharge policies available for review by residents, the resident's representative, and the long-term care ombudsman.

C. Discrimination Prohibited. A nursing home licensed under this chapter may not discriminate in admitting or providing care to an individual because of the individual's:

(1) Race;

(2) Color;

(3) National origin;

(4) Sexual orientation;

(5) Gender identity;

(6) Religion;

(7) Physical disability; or

(8) Mental disability.

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

E. Registry. A nursing home shall maintain a permanent resident registry in which the name of each resident is entered in chronological order with the date and number of entry.

F. Admission Record. A copy of the clinical record, identification, and summary sheet described in Regulation .32 shall be used as an admission record.

G. Before discharge the nursing home shall:

(1) Verify that the transfer and discharge is to a licensed assisted living facility and appropriate to meet the needs of the resident; and

(2) Document the verification in the resident's medical record.

H. Notification of Responsible Persons When Resident Moves. When the resident is transferred from the nursing home for any reason or at time of death, the administrator or the administrator's designee shall notify the attending physician and the:

(1) Private agency;

(2) Public agency; or

(3) Responsible party designated by the resident.

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

(1) Acutely ill and require medical, surgical, or nursing care beyond the capabilities of the facility; or

(2) Dangerous to themselves or others.

.12 Resident's Representative.

A. A nursing home shall recognize the authority of:

(1) A guardian of the person under Estates and Trusts Article, §13-705, Annotated Code of Maryland;

(2) A guardian of the property under Estates and Trusts Article, §13-201, Annotated Code of Maryland;

(3) An advance directive that meets the requirements of Health-General Article, §5-602, Annotated Code of Maryland;

(4) A surrogate decision maker with authority under Health-General Article, §5-605, Annotated Code of Maryland;

(5) A power of attorney that meets the requirements of Estates and Trusts Article, §13-601, Annotated Code of Maryland;

(6) A representative payee or other similar fiduciary; or

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

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

(1) Stated in the instrument that grants the representative authority; or

(2) Established by State law.

C. A facility shall:

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

(2) Include the documentation in the record.

.13 Resident Care Policies.

A. A nursing home shall develop written policies consistent with Regulation .11 of this chapter pertaining to:

(1) Physician services;

(2) Residents' rights;

(3) Nursing services;

(4) Dietetic services;

(5) Specialized rehabilitative services including occupational therapy, physical therapy, speech pathology and audiology services;

(6) Pharmaceutical services;

(7) Laboratory and radiologic services;

(8) Dental services;

(9) Social services;

(10) Resident activities;

(11) Clinical records;

(12) Reports and action required in unusual circumstances;

(13) Utilization review;

(14) Infection control;

(15) Tuberculosis surveillance;

(16) Disaster plan;

(17) Housekeeping services, pest control, and laundry; and

(18) Resident care management.

B. Resident Care Policy.

(1) A nursing home shall develop resident care policies with the advice of:

(a) The principal physician or medical staff or medical director, if applicable; and

(b) At least one registered nurse.

(2) A group of professional personnel including one or more physicians and one or more registered nurses shall review the policies at least annually.

(3) Written policies shall be kept current with the policies used to administer the nursing home.

(4) For reference purposes, copies of the resident care policies shall be readily available to all personnel responsible for resident care.

(5) The nursing home shall make its resident care policies available for review by residents, the resident's representative, and the ombudsman.

C. Policies and Procedures.

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

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

D. Use of Protective Device or Devices.

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

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

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

(4) A resident in a protective device or devices shall be observed periodically by personnel, to ensure that the resident's health and personal care needs are met.

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

.14 Physician Services.

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

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

(a) The individual's medical stability;

(b) Recent and previous medical history;

(c) Presence of significant or previously unidentified medical conditions; or

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) The resident's current condition;

(b) The status of any acute episodes of illness since the last visit;

(c) Test results;

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

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

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

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

(b) A plan to address relevant medical issues.

D. Timeliness of Visits and Progress Notes.

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

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

(a) The resident's medical stability;

(b) Recent and previous medical history;

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

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

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

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

F. Adequate Ongoing Coverage. The attending physician shall:

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

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

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

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

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

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

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

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

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

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

(c) Manage and document ethics issues consistent with relevant laws and regulations and with residents' wishes, including advising residents and families about formulating advance directives or other care instructions and helping identify individuals for whom aggressive medical interventions may not be indicated;

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

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

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

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

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

(9) Properly refer residents to specialty services and providers when the care needs of the resident exceed the scope of the attending physician's knowledge and skill.

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

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

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

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

(b) Route of administration;

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

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

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

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

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

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

.15 Medical Director — Qualifications.

A. Medical Director Qualifications. The nursing home shall:

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

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

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

(c) Successful completion of a curriculum in physician management or administration from:

(i) AMDA: The Society for Post-Acute and Long-Term Care Medicine; or

(ii) A curriculum approved by the Department or its designee;

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

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

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

.16 Medical Director — Responsibilities.

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

(1) Overall coordination, execution, and monitoring of physician services;

(2) Monitoring and evaluating the health care services and outcomes, including clinical and physician services provided to the nursing home's residents; and

(3) Designating an alternate medical director with sufficient training and experience to perform the responsibilities of the medical director as described in the regulations of this chapter.

B. Practitioner Oversight. The medical director shall:

(1) Oversee all physicians and other licensed or certified professional health care practitioners who provide health care to the facility's residents;

(2) Ensure that there is a procedure for the review of the practitioners' credentials and the granting of privileges for licensed or certified professional health care practitioners who treat residents of the nursing facility; and

(3) Recommend rules governing the performance of physicians and other licensed or certified professional health care practitioners who admit residents to the facility.

C. Defining the Scope of Medical Services.

(1) The medical director, in collaboration with the facility, shall recommend written policies and procedures that are approved by the licensee, delineating the scope of physician services and medical care.

(2) The facility shall make these policies and procedures available to a resident or resident's representative upon admission and whenever a substantive change is made.

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

(1) Accepting responsibility for the care of residents;

(2) Supporting resident discharges and transfers;

(3) Making periodic, pertinent resident visits in the facility;

(4) Providing adequate ongoing medical coverage;

(5) Providing appropriate resident care;

(6) Providing appropriate, timely medical orders;

(7) Providing appropriate, timely, and pertinent documentation;

(8) Advising residents and families about formulating advance directives; and

(9) Any other responsibilities as determined by the facility and the medical director.

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

(1) Regular reports and attendance at the nursing home's quality improvement committee meetings; and

(2) Routine participation in ongoing facility efforts to improve the overall quality of the clinical care, including facility efforts to evaluate and address the causes of various care-related problems and deficiencies cited by the Office of Health Care Quality.

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

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

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

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

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

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

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

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

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

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

H. Medical Director Oversight Plan.

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

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

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

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

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

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

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

(3) Documentation Regarding Medical Director Activities.

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

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

(i) Notes;

(ii) Minutes;

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

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

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

.17 Nursing Home's Responsibilities in Relation to the Nursing Home's Medical Director.

A. The nursing facility shall:

(1) Be responsible for working with the medical director to ensure adequate resident care and practitioner performance;

(2) Inform the physician of explicit requirements as a medical director and assist the medical director in gaining the necessary information and tools to properly execute those responsibilities; and

(3) Ensure that the medical director has the necessary support and authority to perform medical director duties effectively and to hold practitioners accountable.

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

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

D. Evaluation of Medical Director's Performance.

(1) The facility shall have a mechanism for evaluating the medical director's performance and for providing the medical director with feedback about that performance.

(2) The criteria for evaluation shall be based on explicit medical director responsibilities and shall facilitate the medical director's improvement and performance of functions and duties.

.18 Nursing Services.

A. Organization, Policies, and Procedures.

(1) Nursing service personnel shall provide care appropriate to the residents' needs with the organizational plan, authority, functions, and duties clearly defined.

(2) Nurses and support personnel shall be chosen for their training, experience, and ability.

(3) Policies and procedures shall be adopted and made available to all nursing service personnel.

B. Signed Agreement.

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

(a) Application for an initial nursing home license; and

(b) A change of director of nursing.

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

C. Nursing Care 24 Hours a Day. The administrator shall employ sufficient and satisfactory licensed nursing service personnel and support personnel to:

(1) Be on duty 24 hours a day;

(2) Provide appropriate bedside care; and

(3) Ensure that a resident:

(a) Receives treatments, medications, and diet as prescribed;

(b) Receives rehabilitative nursing care as needed;

(c) Receives proper care to prevent pressure ulcers and deformities;

(d) Is kept comfortable, clean, and well-groomed;

(e) Is protected from accident, injury, and infection;

(f) Is encouraged, assisted, and trained in self-care and group activities; and

(g) Receives prompt and appropriate responses to requests for assistance.

D. Assistance by Nursing Service Personnel. Nursing service personnel shall help the resident perform daily routine dental hygiene.

E. Charge Nurse.

(1) At least one licensed nurse shall be:

(a) On duty at all times; and

(b) Be designated by the director of nursing to be in charge of the nursing activities during each tour of duty.

(2) The charge nurse or nurses shall have the ability to recognize significant changes in the condition of residents and to take necessary action.

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

(1) Visiting each resident;

(2) Reviewing clinical records, medication orders, resident care plans, and staff assignments; and

(3) To the degree possible, accompanying physicians when visiting residents.

G. Program of Restorative Nursing Care. There shall be an active program of restorative nursing care aimed at assisting each resident to achieve and maintain the individual's highest level of independent function, including activities of daily living. This program shall include:

(1) Ambulation and range of motion;

(2) Maintaining good body alignment and proper positioning of bedfast residents;

(3) Encouraging and assisting residents to change positions at least every 2 hours to stimulate circulation and prevent pressure ulcers and deformities;

(4) Encouraging and assisting residents to keep active and out of bed for reasonable periods of time, within the limitations permitted by physicians' orders;

(5) Encouraging residents to engage in resident-chosen community and independent activities and achieve independence; and

(6) Assisting residents to adjust to their disabilities and ensuring availability and use of their prosthetic and assistive devices.

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

(1) Nursing service personnel are aware of the nutritional needs and food and fluid intake of residents;

(2) Nursing service personnel provide special meals and nourishment when required;

(3) Residents' food choices and preferences are honored as much as practical;

(4) Nursing service personnel promptly aid residents when necessary in eating;

(5) The dietetic service is informed of physicians' diet orders and of residents' nutrition-related issues; and

(6) Food and fluid intake of residents is observed, and deviations from normal are recorded and reported to the:

(a) Charge nurse;

(b) Physician; and

(c) Dietetic service.

I. In-Service Education Program.

(1) The director of nursing shall:

(a) Provide a continuing in-service education program for all nursing service personnel;

(b) Provide a thorough job orientation for new personnel; and

(c) Document the content of the continuing in-service education program and include the names and titles of participants.

(2) The director of nursing shall obtain approval from the Department.

J. Responsibility to Report Care that Is Considered Questionable.

(1) If a nurse questions the care provided to any resident or believes that appropriate consultation is needed and has not been obtained, the nurse shall inform the supervisor.

(2) If indicated, the supervisor shall refer the matter to the director of nursing.

(3) If warranted, the director of nursing shall report the matter to the medical director or principal physician.

.19 Nursing Services — Staffing.

A. Supervisory Personnel — Nursing Homes.

(1) Nursing homes shall provide at least the following supervisory personnel:

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

(2) The director of nursing's time is included in §A(1) of this regulation.

B. Hours of Bedside Care — Nursing Home.

(1) A nursing home shall employ supervisory personnel and a sufficient number of support personnel to provide a minimum of 3 hours of bedside care per occupied bed per day, 7 days per week.

(2) Bedside hours include the care provided by:

(a) Registered nurses;

(b) Licensed practical nurses; and

(c) Support personnel.

(3) Only those hours which the director of nursing spends in bedside care may be counted in the 3-hour minimum requirement.

(4) The director of nursing's time counted in bedside care shall be documented.

C. Staffing in Nursing Home.

(1) A nursing home shall be staffed with at least one registered nurse, 24 hours per day and 7 days per week.

(2) Additional registered nurses, licensed practical nurses, and support personnel shall be employed to meet the needs of all the residents admitted. The nursing home shall be staffed as referenced in §§A and B of this regulation.

D. Nursing Service Personnel on Duty. The ratio of nursing service personnel on duty providing bedside care to residents may not at any time be less than one to 15.

.20 Nursing Services — Director of Nursing.

A. Director of Nursing. The nursing home shall provide for an organized nursing service, under the direction of a full-time registered nurse.

B. Termination of Services of Director of Nursing.

(1) If the nursing home terminates the services of the director of nursing, the nursing home immediately shall notify the Department of the termination.

(2) The name and license number of the replacement director of nursing shall be supplied to the Department as soon as employment begins.

(3) A copy of the agreement between the nursing home and the replacement shall be sent to the Department.

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

D. Relief for Director of Nursing.

(1) When the director of nursing is absent, the individual shall designate an experienced, qualified registered nurse to direct the nursing service.

(2) In a nursing home in which the director of nursing serves as relief for the administrator, the director of nursing shall designate a specific registered nurse who shall be in charge of the nursing service while the director of nursing covers for the administrator.

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

(1) Assisting in the development and updating of statements of nursing philosophy and objectives to define the type of nursing care the nursing home shall provide;

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

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

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

(5) Participation in the coordination of resident services through appropriate staff committee meetings on issues relating to:

(a) Pharmacy;

(b) Infection control;

(c) Resident care policies;

(d) Quality assurance programs; and

(e) Departmental meetings;

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

(7) Ensuring that nursing personnel understand the philosophy and meet the objectives;

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

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

(10) Execution of resident care policies unless delegated to the principal physician or medical director;

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

(12) Coordination of the interdisciplinary resident care management efforts; and

(13) Supervision of certified medicine aides to ensure that the aides act within the limitations and restrictions placed on them.

F. Delegation of Responsibilities. The director of nursing shall make clear any authority delegated to another staff member.

G. Daily Rounds — Director of Nursing.

(1) Although daily rounds are primarily the responsibility of the charge nurse or nurses, the director or assistant director of nursing shall periodically make clinical rounds to nursing units, randomly reviewing clinical records, medication orders, resident care plans, and staff assignments and visiting residents.

(2) Upon request, the director or assistant director of nursing may accompany physicians visiting residents.

H. Director of Nursing's Continuing Education. The director of nursing shall assume responsibility for maintaining professional competence of staff through their participation in education programs.

.21 Dietetic Services.

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

B. Supervision.

(1) In a nursing home with more than 50 beds, overall supervisory responsibilities for the food service department and food production shall be assigned to a full-time qualified dietetic service supervisor. It shall be the responsibility of the supervisor to delegate relief duties to an individual qualified to serve as relief as stated in Regulation .09I of this chapter.

(2) In a nursing home with 50 or fewer beds, exceptions may be made by the Department to allow the supervisor to share cooking responsibilities with the full-time cook.

C. Consultation.

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

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

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

D. Staffing.

(1) A sufficient number of food service personnel shall be employed to perform efficiently the functions of the food and nutrition service and meet the dietary needs of the residents.

(2) Working hours shall be scheduled to ensure that the nutritional needs of the residents are met.

(3) Nursing, housekeeping, laundry, or other personnel may not be used as food service staff. Exceptions, such as in a culture change setting, shall be based on the written approval of the Department. The kitchen may not be used for any purpose other than the preparation of food.

E. Adequacy of Diet.

(1) The food and nutritional needs of residents shall be met in accordance with physicians' orders.

(2) To the extent medically possible, the "Recommended Dietary Allowances" of the Food and Nutrition Board, Commission on Life Sciences, and National Research Council, adjusted for age, sex, and activity, shall be observed.

(3) The "Diet Manual for Long-Term Care Residents", as published by the Department, or any other similar reference material that contains food allowances and guides for regular and therapeutic diets, shall be used.

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

(1) Therapeutic diets shall be planned by a licensed registered dietitian;

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

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

G. Frequency and Quality of Meals.

(1) At least three meals or their equivalent shall be offered daily, at regular times, with not more than 14-hour intervals between the substantial evening meal and breakfast.

(2) A substantial evening meal is an offering of three or more menu items at one time, one of which includes a high quality protein such as meat, fish, eggs, or cheese. This meal represents at least 20 percent of the day's total nutritional requirements.

(3) To the extent medical orders permit, bedtime nourishments shall be offered routinely to all residents.

(4) If a four or five meal a day plan is used, the meal pattern to provide this plan shall be approved by the Department.

H. Advance Planning and Posting of Menus.

(1) Residents shall be given the opportunity to participate in planning menus. Menus shall be written at least 1 week in advance.

(2) The current week's basic menu shall be posted in one or more easily accessible places in the food services department and in the common areas.

(3) Menus shall include alternatives of similar nutritive value that give residents the opportunity to choose meals that they prefer. The dietary preferences of a resident shall be ascertained, including preferences arising from a resident's religious, cultural, and ethnic heritage, and efforts shall be made to meet those preferences.

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

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

K. Preparation of Food.

(1) Foods shall be prepared by methods that conserve nutritive value, flavor, and appearance, and shall be served at proper temperatures, in a form to meet individual needs.

(2) Standardized recipes adjusted to appropriate yield shall be followed. Standardized recipes are those recipes which have been tested by the nursing home or another source and that ensure consistent quality and quantity.

L. Resident-Directed Meal Pattern. If a resident-directed meal pattern is provided, the following is required:

(1) Counseling the residents regarding the risks and benefits of a resident-selected diet which is documented within the medical record; and

(2) Approval of the pattern by both the resident's physician and a licensed registered dietitian.

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

A. Rehabilitative Services — Admission Policies. In a nursing home which does not accept residents in need of specialized rehabilitative services, the minimal acceptable restorative service shall be the restorative nursing care plan designed to maintain function or improve the resident's ability to carry out activities of daily living as set forth in Regulation .18G, of this chapter.

B. Arrangements for Services.

(1) If a nursing home's admission policies include the admission of residents requiring rehabilitative services, the nursing home shall provide, or arrange for under written agreement, specialized rehabilitative services by qualified personnel, such as a physical therapist, speech-language pathologist and audiologist, and occupational therapist.

(2) Initiation of services to meet the rehabilitative needs of the resident shall occur within 48 hours, excluding Saturday, Sunday, and State and federal holidays, of the physician's order for the specialized service.

(3) The resident may not be accepted for admission if at least one service to meet the rehabilitative needs of the resident cannot be initiated within the 48-hour period, excluding Saturday, Sunday, and State and federal holidays.

C. Policies and Procedures.

(1) Written administrative and resident care policies and procedures shall be developed for rehabilitative services by appropriate rehabilitation team members and representatives of the medical, administrative, and nursing staff.

(2) Policies shall provide for the coordination of rehabilitative services and the rehabilitative aspects of nursing.

(3) The nursing home shall make its administrative and resident care policies available for review by residents and the resident's representative.

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

E. Physician's Orders.

(1) Specialized rehabilitative services shall be provided only on written orders of the attending physician.

(2) Orders shall include modalities to be used, frequency, and anticipated goals and shall be made a part of the resident care plan.

(3) The physician shall review with the resident or the family or resident's representative the goals and the treatment program. The frequency of communications between the physician and the rehabilitation team members shall depend on changes in the resident and the resident's medical status.

F. Progress Notes.

(1) Within 2 weeks of referral to specialized rehabilitative services, the rehabilitation team members shall provide the attending physician with a written report of the evaluation, including goals and progress of the resident.

(2) Progress notes related to rehabilitative services shall be written at least every 2 weeks.

G. Reevaluation of Resident's Progress.

(1) The physician and the rehabilitation team members shall reevaluate the resident's progress as necessary, but at least every 30 days.

(2) The physician may document on the record that the reevaluation may be less frequent but in no case may the reevaluation exceed 60 days.

H. Resident's Record.

(1) The physician's orders, the initial evaluations, the plan of rehabilitative care, goals, services rendered, evaluations of progress, and other pertinent information shall be:

(a) Recorded in the resident's medical record; and

(b) Dated and signed by the:

(i) Physician ordering the service; and

(ii) Those disciplines who provided the service.

(2) The record and progress notes concerning the resident shall reflect at all times the most recent and current status of the resident, including current short-term and long-term goals.

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

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

.23 Special Care Units — General.

A. A nursing home which holds a current and valid operating license may establish special care units with the approval of the:

(1) Office of Health Care Quality; and

(2) Department's Office of Capital Planning, Budgeting and Engineering Services.

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

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

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

(2) An organization chart of the special care unit and its relationship to the rest of the nursing home;

(3) A description of staffing patterns;

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

(5) A quality assurance plan which includes:

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

(b) Identification of the predominant aspects of care provided;

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

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

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

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

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

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

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

(6) Policies and procedures, including:

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

(b) The administration of medications that are relevant to the special care residents in the special care units;

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

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

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

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

(8) Protocols for emergency situations; and

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

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

E. Physician Coordinator.

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

(a) Overall medical supervision of the special care unit; and

(b) Coordination of all services for the assigned special care unit.

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

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

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

(b) Be available to provide any required consultation.

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

G. Nursing Services.

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

(2) Nursing staff shall be:

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

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

H. Design.

(1) A special care unit shall meet the general construction requirements of Regulations .08, .42, and .41 of this chapter, and the requirements in this regulation.

(2) The nursing home shall ensure that floor space allocated to each bed meets minimum requirements listed in Regulation .49 of this chapter, and is sufficient to accommodate the special equipment necessary to meet the needs of residents.

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

J. Quality Assurance Program. The facility shall:

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

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

.24 Special Care Units — Respiratory Care Unit.

A. A respiratory care unit shall meet the:

(1) General requirements established for all special care units as outlined in Regulation .23 of this chapter; and

(2) Requirements of this regulation.

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

(1) All documents required in Regulation .23 of this chapter;

(2) Policies and procedures for all aspects of care as outlined in Regulation .23 of this chapter, and the following:

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

(i) Cardiopulmonary resuscitation;

(ii) Obtaining arterial blood gas samples and their analyses;

(iii) Pulmonary function testing;

(iv) Therapeutic chest percussion and vibration;

(v) Bronchopulmonary drainage;

(vi) Coughing and breathing exercises;

(vii) Mechanical ventilatory and oxygenation support for residents; and

(viii) Aerosol, humidification, and medical gas administration;

(b) Weaning from mechanical ventilatory support and discharge planning for residents of the respiratory care unit; and

(c) The procurement, handling, storage, and dispensing of medical gases.

C. Physician Coordinator. If the nursing home's medical director does not have special training and experience in diagnosing, treating, and assessing respiratory problems, the nursing home shall employ or contract with a Board-certified pulmonologist who has the special knowledge and experience to provide:

(1) Overall medical supervision of the respiratory care unit; and

(2) Coordination of all services for the respiratory care unit.

D. Staffing. The nursing home shall ensure that:

(1) The nurse manager or the director of nursing of vent units has a background in ventilator care or is qualified in ventilator management;

(2) Respiratory care services are provided by a sufficient number of qualified personnel; and

(3) Respiratory care personnel provide respiratory care services commensurate with their documented training, experience, and competence.

E. Design.

(1) Emergency Power. The nursing home unit shall meet all applicable requirements in Regulation .46 of this chapter for emergency electrical power, including the provision of:

(a) Emergency lighting in the respiratory care unit where life support equipment is used; and

(b) Duplex receptacles connected to the facility's emergency generator to provide emergency power to operate life support equipment and nonflammable medical gas systems in the respiratory care unit.

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

(3) Piped Medical Gas Systems.

(a) To service the medical gas systems, a vendor or staff shall be trained and accredited in accordance with NFPA 99 Health Care Facilities Code.

(b) The vendor or staff may provide the following services:

(i) Installation;

(ii) Inspection; or

(iii) Testing.

(c) The nursing home shall ensure that all piped medical gas systems adhere to the following standards:

(i) NFPA 99 Health Care Facilities Code; and

(ii) NFPA 101 Life Safety Code.

F. The nursing home shall provide pulmonary function testing and blood gas or pulse analysis capability on-site or through contractual arrangements with providers who meet applicable State and federal laws and regulations.

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

(1) Approve the contractor based on the contractor's credentials, training, and experience;

(2) Ensure that all contractors:

(a) Provide services 24 hours a day;

(b) Meet all safety requirements;

(c) Abide by all pertinent policies and procedures of the facility;

(d) Provide services in accordance with all laws and regulations governing the facility; and

(e) Participate in the monitoring and evaluation of the appropriateness of services provided as required by the facility's quality assurance program; and

(3) Ensure that all contractual services receive overall medical supervision and coordination by the facility's physician coordinator of the respiratory care unit.

.25 Special Care Units — Dementia Care Unit.

A. A dementia care unit shall meet the:

(1) General requirements established for all special care units as outlined in Regulation .24 of this chapter; and

(2) Requirements of this regulation.

B. Dementia Unit Disclosure.

(1) The disclosure shall be made to the Department and to any person seeking placement or receiving care in a Dementia special care unit or program of a nursing home.

(2) The information disclosed shall explain the additional care provided in each of the following areas:

(a) The Dementia special care unit's written statement of its overall philosophy and mission, which reflects the needs of residents with dementia;

(b) The process and criteria for placement, transfer, or discharge from the unit;

(c) The process used for individualized assessment and establishing the resident-centered plan of care and its implementation, including the method by which the plan of care evolves and is responsive to changes in the individual's condition;

(d) Staff training and continuing education practices;

(e) The physical environment and design features appropriate to support the functioning of cognitively impaired adult residents;

(f) The frequency and types of resident activities;

(g) The involvement of families and family support programs; and

(h) The cost of care and any additional fees.

C. Secured units shall meet the established standards applicable to nursing home set forth in NFPA 99 Health Care Facilities Code and NFPA 101 Life Safety Code.

.26 Pharmaceutical Services.

A. Definition. In this regulation, the term "committee" means the pharmaceutical services committee.

B. Duties of the Nursing Home.

(1) The nursing home shall provide appropriate methods and procedures for administering drugs and biologicals to the nursing home's residents.

(2) The nursing home shall provide pharmaceutical services in accordance with accepted professional standards and related federal, State, and local laws.

C. Duties of the Pharmaceutical Services Committee.

(1) A pharmaceutical services committee, or its equivalent, shall develop written policies and procedures for safe and effective drug therapy, distribution, control, and use.

(2) The composition of the committee shall include at least:

(a) The licensed pharmacist;

(b) The director of nursing;

(c) The consultant dietitian-nutritionist;

(d) One physician; and

(e) The administrator.

(3) The committee shall meet at least quarterly to establish policies and procedures.

(4) There shall be an agenda to guide meeting participants.

(5) All members of the committee shall review revisions of policies and procedures before implementing any changes.

(6) The pharmaceutical services committee may not develop policies and procedures that prohibit or restrict a resident from receiving medications from the pharmacy of the resident's choice.

(7) In cases where the cost of any medication obtained from the pharmacy selected by the resident exceeds the cost of the same or equivalent medication available through a pharmacy that the nursing home has contracted with to provide pharmaceutical services, the resident shall be responsible for the additional amount.

(8) The committee may not require the pharmacy to provide drugs by way of a specific drug distribution system such as unit dose or use of a particular packaging system.

(9) The committee shall establish the contents of sealed emergency drug kits.

(10) The committee shall oversee the accuracy and adequacy of pharmaceutical services to the nursing home.

(11) The committee shall make recommendations for improvements to pharmaceutical services.

(12) The committee shall document its actions and recommendations.

D. Labeling.

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

(a) The resident's full name;

(b) The name of the drug;

(c) Strength;

(d) Original filling date and date refilled, if applicable;

(e) Name of authorized prescriber;

(f) Expiration date of medication (month, year);

(g) Any special handling and storage instructions;

(h) Name and address of dispensing pharmacy;

(i) Prescription number;

(j) Number of tablets or capsules; and

(k) Accessory federal labels.

(2) A nurse may not package, repackage, bottle, or label any medication, in whole or in part, or alter any labeled medication in any way.

E. Storage.

(1) The nursing home shall store medications in a locked medication storage area that:

(a) Is well lighted;

(b) Is located where personnel preparing drugs for administration will not be interrupted;

(c) Is spacious enough to allow separate storage of external and internal medications;

(d) Is kept in a clean, orderly and uncluttered manner; and

(e) Contains a refrigerator to be used for medication storage only.

(2) The nursing home shall keep poisons and medications marked "for external use only" separate from general medications and Schedule II drugs.

F. Schedule II—IV Drugs.

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

(2) A nurse and a second staff member who is a nurse or an administrator may destroy controlled dangerous substances in Schedules II—V on the premises of the nursing home.

(3) If a controlled dangerous substance is destroyed on the nursing home premises in accordance with §F(2) of this regulation:

(a) A record of the disposal, in addition to any other required records, shall be maintained in the nursing home; and

(b) A copy of the record of disposal shall be forwarded to the Office of Controlled Substances Administration.

(4) A nursing home, whether or not operating a licensed pharmacy, shall maintain a signed record of a Schedule II count at each change of shift.

(5) A nursing home that administers Schedule II drugs shall maintain a drug record that documents:

(a) The name of the resident;

(b) The date, time, kind, dosage, and method of administration of all Schedule II drugs; and

(c) The name of the authorized prescriber who prescribed the medication.

.27 Pharmaceutical Management.

A. Administration Procedures.

(1) Medications, legend and non-legend, administered to residents shall be ordered in writing by the resident's physician.

(2) Medications shall be administered by:

(a) Appropriately licensed personnel in accordance with laws and regulations governing these acts; or

(b) Certified graduates of a State-approved medicine aide course.

(3) The individual who prepares medications shall give and record them.

(4) Medicine may not be returned to the container. If the resident refuses the drug or if a mistake occurs:

(a) The drug shall be discarded; and

(b) The occurrence shall be documented in the resident's chart.

(5) Before invoking stop order policies, the resident's attending physician shall be contacted for instructions so that continuity of the resident's therapeutic regimen is not interrupted. If the attending physician cannot be reached, the medical director shall be contacted for instructions.

B. Pharmaceutical Services.

(1) The nursing home shall arrange for pharmacies that provide medications for residents in the nursing home. The pharmacy shall agree in writing to maintain at the pharmacy a resident profile record system for each resident in the nursing home for whom prescriptions are dispensed.

(2) If the nursing home does not employ a licensed pharmacist, the nursing home shall arrange by written contract for a pharmacy to provide consultation on administering the pharmacy services in accordance with the policies and procedures established by the pharmaceutical services committee. Pharmaceutical services shall be under the general supervision of a licensed pharmacist who shall:

(a) With the advice of the pharmaceutical services committee, be responsible for developing, coordinating, and supervising pharmaceutical services and provide in-service training at least twice yearly;

(b) Visit the nursing home frequently enough to ensure that policies and procedures established by the pharmaceutical services committee are enforced;

(c) Notify the attending physician of any potential drug problems found during the drug regimen review; and

(d) At least quarterly, submit a report to the pharmaceutical services committee on the status of the nursing home's pharmaceutical services and staff adherence to policies and procedures.

C. Resident-Designated Pharmacy.

(1) The nursing home shall inform a resident's designated pharmacy about the nursing home's written policies concerning the provision of drugs.

(2) To provide services to the resident, a designated pharmacy shall agree to comply with the nursing home's policies.

(3) If the pharmacy fails to comply with the policies, a representative of the nursing home shall discuss the situation with the pharmacy and the resident, and if the pharmacy subsequently refuses to follow the policies, the resident shall select another pharmacy that agrees to comply.

(4) The pharmacy shall have access to a copy of the written pharmaceutical care policies.

(5) The pharmacy shall be responsible for delivering medications to the nursing home. Members of the resident's family or the responsible party for the resident may not deliver medications to the resident or to the nursing home.

D. Medication Return and Disposal.

(1) The nursing home shall return all prescribed medications, for residents who have been discharged or otherwise departed, to the pharmacy in accordance with the nursing home's policy.

(2) The nursing home shall destroy adulterated, deteriorated, or outdated medications in the following manner:

(a) Disposal shall occur in the presence of two witnesses who are authorized by the nursing home; and

(b) The witnesses shall document the disposal in the resident's chart.

(3) The nursing home shall only release prescribed medications to residents at the time of discharge based on the written authorization of the resident's authorized prescriber.

(4) Each month, the nursing home shall perform a drug regimen review on each resident's records at the nursing home and document the findings in the resident's medical record.

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

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

(2) In accordance with a nursing home-developed procedure, a licensed nurse shall prepare medications to be sent with a resident during a short-term leave of absence of 24 hours or less.

.28 Laboratory and Radiologic Services.

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

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

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

D. Reports of Findings. The nursing home shall notify the attending physician promptly of the findings. The nursing home shall file signed and dated reports of diagnostic services in the resident's medical record.

E. Transportation. The nursing home shall assist the resident, if necessary, in arranging transportation to and from the source of service.

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

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

H. Transfusion Services. If the nursing home only provides transfusion services, it shall meet at least the requirements established under COMAR 10.10.02.

.29 Dental Services.

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

B. Advisory Dentist. There shall be an advisory dentist who shall:

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

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

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

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

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

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

.30 Social Work Services.

A. Services Provided. The nursing home shall provide or make arrangements for services to identify and meet the resident's medically related physical, social, and behavioral health needs.

B. Social Work Staff Responsibility.

(1) Social services responsibilities in the nursing home shall be assigned to a:

(a) Licensed bachelor social worker;

(b) Licensed graduate social worker;

(c) Licensed certified social worker; or

(d) Licensed certified social worker–clinical.

(2) If the social worker is not a licensed certified social worker (LCSW) or a licensed certified social worker-clinical (LCSW-C), the nursing home shall arrange for an LCSW or LCSW-C to provide sufficient hours of supervision.

(3) As of January 1, 2021, a license is required for an employee to provide social services except if:

(a) On the effective date of these regulations, the employee was assigned responsibility for social services; and

(b) The nursing home has an agreement with a qualified social work consultant that provides for sufficient hours of supervision to assure that the employee's services meet the medically related physical, social, and behavioral health needs of the residents.

C. Social History. Within 7 days after admission, the social worker shall initiate a written social history, which shall be as complete as possible and shall include:

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

(2) Information regarding current personal and family circumstances and attitudes as they relate to the resident's illness and care; and

(3) Information regarding the resident's and family's plans regarding discharge.

D. Records. Records shall include the information required in §C of this regulation.

E. Space. A nursing home shall provide:

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

(2) Privacy for interviews.

.31 Resident Activities.

A. Activities Program. The nursing home shall provide:

(1) A program of structured and unstructured activities; and

(2) Activities designed and monitored appropriately to meet the day-to-day needs and interests of each resident and encourage:

(a) Self-care;

(b) Engagement in resident-selected activities; and

(c) Maintenance of an optimal level of psychosocial functioning.

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

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

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

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

F. Space, Supplies. The nursing home shall provide adequate space and a variety of supplies and equipment to satisfy the appropriate individual activity needs of residents.

.32 Clinical Records.

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

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

(1) Identification and summary sheet or sheets including:

(a) Resident's name;

(b) Social Security number;

(c) Armed forces status;

(d) Citizenship;

(e) Marital status;

(f) Age;

(g) Sex;

(h) Home address; and

(i) Religion;

(2) Names, addresses, and telephone numbers of referral agencies, including:

(a) Hospital from which admitted;

(b) Personal physician;

(c) Dentist;

(d) Parents' names or next of kin; and

(e) Resident's representative;

(3) Documentation of the:

(a) Needs of the resident;

(b) Establishment of an appropriate initial and ongoing treatment plan; and

(c) Care and services provided;

(4) Authentication of hospital diagnoses, based on a:

(a) Discharge summary;

(b) Report from the resident's attending physician; or

(c) Transfer form;

(5) Consent forms when required, such as:

(a) Administration of investigational drugs;

(b) Burial arrangements made in advance;

(c) Release of medical record information; and

(d) Handling of finances;

(6) Medical and social history of the resident;

(7) Report of physical examination;

(8) Diagnostic and therapeutic orders;

(9) Consultation reports;

(10) Observations and progress notes;

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

(12) Discharge summary including final diagnosis and prognosis;

(13) Assessments done by various disciplines; and

(14) Interdisciplinary care plan.

C. Staffing. An employee of the nursing home shall be designated as the person responsible for the overall supervision of the medical records service. There shall be sufficient support staff to accomplish all medical records functions.

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

E. Completion of Records and Centralization of Reports.

(1) Current medical records and those of discharged residents shall be completed promptly.

(2) All clinical information pertaining to a resident's stay shall be centralized in the resident's medical record.

F. Retention and Preservation of Records.

(1) Medical records shall be retained for a period of at least 5 years from the date of discharge or, in the case of a minor, 3 years after the resident becomes of age or 5 years, whichever is longer.

(2) The nursing home shall maintain and dispose of a resident's medical records in accordance with Health-General Article, Title 4, Subtitles 3 and 4, Annotated Code of Maryland.

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

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

I. Electronic Health Records.

(1) A nursing home that uses electronic health records exclusively or along with a paper-based medical record shall comply with this chapter and all applicable State and federal laws, including laws governing privacy and security of records.

(2) Staff and nursing home-approved practitioners shall be trained in the use of electronic health records.

(3) A nursing home that uses electronic health records shall:

(a) Ensure access to residents as specified in COMAR 10.07.09.08C(13) and (14); and

(b) On request, provide the resident with copies of the resident's medical records at a reasonable cost and in the resident's preferred format.

(4) A nursing home shall provide full access to electronic health records in accordance with all applicable laws and regulations to:

(a) Representatives of the Department as set forth in COMAR 10.07.02.07;

(b) An ombudsman as set forth in Human Services Article, §10-905, Annotated Code of Maryland; and

(c) Other legal representatives as set forth in COMAR 10.07.09.08 and authorized by law to obtain access.

(5) A nursing home shall develop a system to ensure that nursing home staff have access to residents' health records in the event of a failure of the nursing home's electronic medical record system.

.33 Infection Prevention and Control Program.

A. Infection Prevention and Control Program. The nursing home shall establish, implement, and maintain an effective infection prevention and control program that:

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

(a) Analyze patterns of infected individuals;

(b) Analyze changes in prevalent organisms;

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

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

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

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

(4) Monitors and evaluates the:

(a) Effectiveness of the infection prevention and control program by surveying rates of infection, especially infection rates that are significantly higher than usual; and

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

B. Infection Preventionist.

(1) The nursing home shall assign at least one infection preventionist that has attended training in infection surveillance, prevention, and control to actively manage the nursing home's infection prevention and control program.

(2) The infection preventionist shall attend or have attended a basic infection prevention and control training course that is approved by the:

(a) Office of Health Care Quality; and

(b) Office of Infectious Disease Epidemiology and Outbreak Response for the Department.

(3) This position shall be staffed at a ratio of 1.0 Full Time Equivalents for every 200 beds.

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

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

E. Infection Prevention and Control Policies and Procedures.

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

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

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

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

(d) Perform surveillance for health care-associated and community-associated infections of residents and employees using definitions and methods approved by the infection prevention and control oversight committee to monitor and investigate causes of infection, and the manner in which the infection is spread;

(e) Train employees about infection prevention and control, including:

(i) Standard precautions and hand hygiene;

(ii) Respiratory hygiene and cough etiquette;

(iii) Soiled laundry and linen processing;

(iv) Safe handling of needles and sharps and safe injection techniques;

(v) Special medical waste handling and disposal;

(vi) Appropriate use of antiseptics and disinfectants;

(vii) Blood-borne pathogens, including hepatitis B and C and human immunodeficiency virus;

(viii) Tuberculosis exposure; and

(ix) Proper use and wearing of personal protective equipment, such as gloves, gowns, and eye protection;

(f) Train and perform compliance monitoring of employee application of infection prevention and control activities, such as hand hygiene and personal protective equipment used for isolation precautions;

(g) Review the infection prevention and control program elements at least annually and revise as necessary; and

(h) Obtain annual approval of infection prevention and control program activities by the infection prevention and control oversight committee.

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

(3) The nursing home shall obtain information concerning the infectious disease status of any resident being transferred or admitted to the nursing home from elsewhere.

F. Preventing Spread of Infection.

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

(2) The nursing home shall take appropriate infection prevention and control measures to prevent the transmission of an infectious disease to residents, employees, and visitors as outlined in the following guidelines:

(a) 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings; and

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

(3) The nursing home shall prohibit employees with an infectious disease or with infected skin lesions from having direct contact with residents or their food if direct contact could transmit the disease.

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

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

.34 Employee Health Program.

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

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

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

(3) COMAR 09.12.31.

B. Tuberculosis Exposure Control.

(1) The infection control program shall include a risk assessment program, including monitoring for tuberculosis infection for employees that is in accordance with the Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings.

(2) The nursing home shall ensure that employees may not provide services that require direct access to residents without documented evidence that the employee is free from communicable tuberculosis.

(3) A new employee shall be assessed for risk of tuberculosis through:

(a) A two-step tuberculin skin testing at the time of hire following guidelines referenced in the Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings; or

(b) An interferon-gamma release assay (IGRA) blood test.

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

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

(b) Any previous tuberculin skin tests, chest x-ray, or blood test results, chemotherapy, and chemoprophylaxis that are the basis for certifying that the individual is free from tuberculosis in a communicable form.

C. Measles, Mumps, Rubella, and Varicella.

(1) The nursing home shall screen and maintain written documentation of each employee's proof of immunity to common childhood infections including measles, mumps, rubella, and chickenpox (varicella). Proof of immunity to these diseases shall be verified by:

(a) Documented evidence of administration of vaccine; or

(b) Laboratory evidence of immunity.

(2) The nursing home shall require that employees who are not immune to measles, mumps, rubella, and varicella receive immunization for measles, mumps, rubella, or varicella, unless medically contraindicated or against the employee's religious beliefs. If the employee refuses to be immunized, the nursing home shall document the refusal and the reason for it.

D. Hepatitis B. The nursing home shall require that all new employees receive immunization for Hepatitis B, unless medically contraindicated, against the employee's religious beliefs, or after being fully informed of the health risks of not being immunized. The nursing home shall inform all new and current employees of the health risks of not being immunized. If the employee refuses to be immunized, the nursing home shall document the refusal and the reason for the refusal.

E. Influenza.

(1) The nursing home shall require that all employees receive annual immunization for influenza, unless:

(a) Medically contraindicated;

(b) Against the employee's religious beliefs; or

(c) After being fully informed of the health risks associated with not receiving a vaccine, the employee refuses the immunization.

(2) The nursing home shall:

(a) Comply with Health-General Article, §18-404, Annotated Code of Maryland, regarding immunizations of employees;

(b) Inform all new and current employees of the health risks of not being immunized;

(c) Document refusals; and

(d) Require that any employee who is not vaccinated with the current influenza vaccine wear a mask when:

(i) Within 6 feet of a resident; and

(ii) During the influenza season as specified by the State's Prevention and Health Promotion Administration, based on influenza activity in Maryland.

F. Pertussis. The nursing home shall:

(1) Require that each new employee receive a one-dose booster immunization for pertussis, unless medically contraindicated or against the employee's religious beliefs;

(2) Inform all new and current employees of the health risks of not being immunized;

(3) Document any refusals of immunization; and

(4) Ensure that the immunization is given in the form of Tdap (tetanus, diphtheria, acellular pertussis) vaccine, in accordance with the guidelines prescribed in Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Health Care Infection Control Practices Advisory Committee (HICPAC).

.35 Resident Health Program.

A. Immunization.

(1) The nursing home shall offer influenza and pneumococcal immunization to each resident.

(2) The nursing home shall obtain written consent to administer the immunization from:

(a) The resident; or

(b) The resident's representative.

(3) A resident is not required to receive the influenza and pneumococcal immunization if it is:

(a) Medically contraindicated;

(b) Against the resident's religious beliefs; or

(c) After being fully informed of the health risks associated with not receiving a vaccine, the resident refuses the immunization.

(4) If the resident refuses to be immunized, the nursing home shall document the refusal and the reason for the refusal.

(5) The nursing home shall notify each prospective resident of the immunization requirements and request that the resident agree to be immunized.

(6) The nursing home shall make available to residents educational and informational materials relating to immunization against influenza virus and immunization against pneumococcal disease.

B. Tuberculosis Assessment.

(1) The nursing home shall assess residents for tuberculosis according to the Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Settings.

(2) A new resident shall receive a two-step tuberculin skin test within 10 days of admission to the nursing home unless the resident has had:

(a) A documented negative tuberculin skin test within the previous 12 months;

(b) A previous positive tuberculin skin test;

(c) A history of preventive therapy treatment;

(d) A latent infection; or

(e) The treatment of active tuberculosis.

(3) The nursing home shall continue to monitor residents for signs and symptoms of tuberculosis by performing a yearly symptom review. When a resident has signs and symptoms of tuberculosis, a physician shall be notified to:

(a) Evaluate the resident for possible tuberculosis in a communicable form;

(b) Notify the health officer within 24 hours if the physician suspects tuberculosis; and

(c) Coordinate management of the resident and the resident's contacts with the local health officer.

(4) The nursing home shall assess and manage a resident with a history of a previous positive tuberculin skin test, a history of latent infection, or a previous history of active tuberculosis, in accordance with Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings.

.36 Volunteer Health Program.

A. The nursing home shall urge that volunteers, defined as individuals who spend an average of 8 hours per week or more in the resident care areas and who receive no pay or benefits, receive annual influenza vaccination and tuberculin skin testing as considered necessary by the nursing home.

B. The nursing home shall give appropriate health care information to such volunteers to provide maximum protection to residents.

C. The nursing home shall maintain documentation of the discussion between the nursing home and the volunteer concerning influenza vaccine and tuberculin skin testing.

.37 Infection Control — Standard Precautions.

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

(1) 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings; and

(2) COMAR 09.12.31.

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

C. A nursing home shall maintain, at all times, the capability to physically isolate any resident who may contract a communicable disease from the remaining resident population. To provide for this, a nursing home shall have at least one private bedroom with an attached private bathroom that includes a:

(1) Toilet;

(2) Hand-washing sink; and

(3) Bathtub, shower, or other bathing device.

.38 Reports and Action Required in Unusual Circumstances.

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Unusual Occurrences.

(1) The administrator of the nursing home shall immediately report to the local health department and the Department the occurrence of:

(a) Infectious disease;

(b) Poisoning;

(c) Internal emergency or disaster;

(d) External emergency or disaster,

(e) Any symptomatic condition of importance to public health that affects the nursing home; or

(f) Any other serious occurrence that threatens the welfare, safety, or health of any resident.

(2) The administrator of the nursing home shall be responsible for ensuring that appropriate procedures and reporting are carried out for all reportable infections. An occurrence of a confirmed or suspected infection shall be reported and acted on in accordance with COMAR 10.06.01 and COMAR 10.15.03.

.39 Transfer Agreement.

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

(1) Planning to ensure that all services required for the continuity of resident care will be made available promptly;

(2) Advance discussion with the resident regarding the reason for the transfer and any available alternatives;

(3) Notification to the next of kin or responsible person regarding the anticipated transfer;

(4) Interchange of medical and other information necessary in the care and treatment of residents transferred between facilities, including notification of the licensed pharmacist of resident transfer;

(5) Safe and timely transportation and care of the resident during transfer;

(6) Security and accountability for the resident's personal effects;

(7) Prompt readmission to the nursing home at the end of the hospital stay;

(8) Annual review of transfer arrangements by a utilization review committee or other designated group to ensure that each party is fulfilling the needs of the residents, the providers, the hospital, and the nursing home;

(9) If needs are not being met, the administrator of the nursing home shall act on recommendations of the reviewing group to effect compliance;

(10) Before licensure, the comprehensive care facility or the extended care facility shall submit to the Department a copy of the written agreement, signed by persons authorized to execute the agreement on behalf of the facilities;

(11) Each facility shall maintain a signed copy of the agreement.

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

C. Human remains shall be transported pursuant to COMAR 10.29.21.

.40 Emergency and Disaster Plan.

A. Emergency and Disaster Plan.

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

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

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

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

(d) The continuity of services, including:

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

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

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

(iv) Reasonable efforts to continue care.

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

(a) Resident's name;

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

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

(3) When the nursing home relocates residents, the nursing home shall send a medical fact sheet and any medically related information with each resident that includes at a minimum the resident's:

(a) Name;

(b) Medical condition or diagnosis;

(c) Medications;

(d) Allergies;

(e) Special diets or dietary restrictions;

(f) Family or legal representative contact information; and

(g) Advance directives, living will, or a copy of the resident's Maryland's Medical Orders for Life-Sustaining Treatment (MOLST) form.

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

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

(b) Reviewed at least monthly; and

(c) Maintained in a written, electronic, or printed form in a central location readily accessible and available to accompany residents in case of an emergency evacuation.

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

(6) The licensee shall:

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

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

(7) The licensee shall:

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

(b) Document an agreement with each transportation source.

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

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

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

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

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

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

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

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

(11) Maryland Health Alert Network.

(a) A nursing home shall register with the Maryland Health Alert Network.

(b) A nursing home shall register at least four representatives, including the administrator and the director of nursing.

(c) Following any changes in the initial registration of the four representatives, a nursing home shall update the information within 5 business days of the change.

(12) The licensee shall:

(a) Identify an emergency and disaster planning liaison for the nursing home; and

(b) Provide the liaison's contact information to the local emergency management organization.

(13) The licensee shall prepare an executive summary of the nursing home's evacuation procedures to provide to a resident, family member, or resident's representative upon request. The summary shall, at a minimum:

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

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

(c) Describe means of communication with family members and resident's representatives;

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

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

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

C. Orientation and Drills.

(1) The licensee shall:

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

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

(c) Within 24 hours of admission, notify and direct residents to the nursing home's emergency plans and maps, including evacuation procedures.

(2) Fire Drills.

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

(b) The licensee shall:

(i) Document completion of each drill;

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

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

(3) Semiannual Emergency and Disaster Drill.

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

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

(c) Documentation. The licensee shall:

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

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

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

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

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

.41 Physical Plant — New and Existing Construction Requirements.

A. Construction of a New Nursing Home.

(1) A new nursing home shall be constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public.

(2) A nursing home desiring to provide services other than those for which it is already licensed shall obtain prior approval from the Department.

(3) The nursing home shall obtain prior approval from the Department for any part of the premises to be used for tenant occupancy or for unrelated business purposes.

(4) A nursing home shall be constructed in accordance with the provisions of the NFPA 101 Life Safety Code.

B. Construction in an Existing Structure. In existing structures, the Department shall entertain requests for waivers on items that:

(1) Will not endanger the health and safety of residents, visitors, employees, and other individuals using the nursing home; and

(2) If corrected, will result in an unreasonable, substantial financial burden on the nursing home.

C. Conversion of an Existing Structure. When an owner plans to convert an existing structure that has not been licensed as a nursing or care home to a nursing home, the owner shall be required to meet all conditions set forth in this chapter.

D. Preventative Maintenance Program. A nursing home shall have a documented preventative maintenance program. This program shall include:

(1) Periodic service and testing of items as recommended by manufacturers of at least the following:

(a) Building systems;

(b) Building components;

(c) Resident care equipment;

(d) Resident therapy equipment;

(e) Resident bathing and shower equipment;

(f) Furniture and furnishings;

(g) Wheelchairs;

(h) Walkers;

(i) Body lifts;

(j) Scales;

(k) Electronics; and

(l) Electrical switches and outlets;

(2) Ongoing staff monitoring for evidence of malfunction or deterioration; and

(3) A centralized system for reporting and monitoring repairs.

.42 Physical Plant — General Requirements.

A. Unless otherwise indicated, all general requirements apply to both new construction and an existing nursing home.

B. A nursing home shall comply with all applicable federal, State, and local governing laws, regulations, standards, ordinances, and codes.

C. A nursing home shall be constructed to comply with the provisions of the NFPA 101 Life Safety Code, as promulgated by the State Fire Prevention Commission, that are applicable to nursing homes.

D. Securely anchored handrails:

(1) Shall be provided on each side of all corridors in resident areas; and

(2) May not be more than 36 inches high as measured from the floor to the top of the handrail.

E. Elevators.

(1) New Construction. Elevators shall meet the requirements for elevators in a long-term care nursing home as set forth in the Guidelines for Design and Construction of Residential, Health, Care, and Support Facilities.

(2) Existing Facilities. An existing nursing home shall meet all local codes and standards for safety and maintenance of institutional elevators.

F. Lighting.

(1) A resident's room shall:

(a) Be lighted by outside windows; and

(b) Have artificial light adequate for reading and other uses as required.

(2) In order to prevent accidents and promote efficiency of service, the nursing home shall ensure that the following areas have sufficient artificial lighting:

(a) Entrances;

(b) Hallways;

(c) Stairways;

(d) Inclines;

(e) Ramps;

(f) Basements;

(g) Attics;

(h) Storerooms;

(i) Kitchens;

(j) Laundries; and

(k) Service units.

G. Minimally Maintained Lighting Levels. The following table lists the minimum lighting requirements in the following given areas:

Area	Minimum Lighting
(1) Administrative areas	30 foot-candles

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

H. Night Lights.

(1) A nursing home shall have sufficient lighting at night in the following areas:

(a) Hallways;

(b) Stairs; and

(c) Designated toilets of the nursing home for the safety of the resident who gets up during the night.

(2) There shall be at least one night light in each bedroom for residents.

(3) In new construction, the night light shall be located at the resident room door and be capable of being switched on and off.

I. Screens.

(1) A nursing home shall ensure that screened doors and windows are installed and maintained in accordance with applicable fire and safety codes and COMAR 10.15.03 Food Service Facilities.

(2) Maintenance and installation may not conflict with other applicable laws, regulations, codes, or ordinances.

(3) A nursing home shall equip all screened doors with self-closing devices, to provide for the normal flow of ingress and egress of traffic.

(4) A nursing home shall screen with wire screen or its equivalent, not less than 16 meshes per linear inch for doors and windows that provide ventilation.

J. Garbage Disposal.

(1) Garbage shall be:

(a) Stored in water-tight containers with tight-fitting covers; and

(b) Emptied at frequent intervals.

(2) Soiled containers shall be thoroughly scoured and aired before using again.

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

L. Burning. A nursing home may not burn or incinerate garbage at the nursing home.

M. Special Medical Wastes. The nursing home shall meet the requirements for handling, treatment, and disposal of special medical wastes as provided in COMAR 10.06.06.

N. Smoking.

(1) Resident Smoking Requirements.

(a) A resident who smokes shall be assessed for safe smoking behaviors at admission and on significant changes in condition.

(b) A resident assessed to exhibit unsafe behaviors shall have a care plan to ensure the resident is safe when smoking.

(2) Nursing Home Smoking Requirements.

(a) Smoking areas shall be designated.

(b) Smoking shall be prohibited at the main entrance to all facilities.

(c) All tobacco products shall be extinguished and disposed of in noncombustible containers with self-closing lids in accordance with the provisions of NFPA 101 Life Safety Code.

O. A nursing home shall be protected throughout the entire building by an automatic fire extinguishing system.

.43 Physical Plant — Plumbing.

A. Unless otherwise indicated, all general requirements apply to both new construction and an existing nursing home.

B. Plumbing.

(1) Plumbing shall be installed in conformance with all applicable federal, State, and local codes and ordinances.

(2) Plumbing and water supplies shall be protected against backflow within a nursing home.

(3) Prevention of backflow shall be ensured by proper installation of:

(a) Plumbing cross-connections;

(b) Submerged inlets; and

(c) Back siphonage.

C. Sewage. The nursing home shall be serviced by a public sewage disposal system if available.

D. Private Sewage Disposal Approval.

(1) If no approved public sewerage system is available, a private sewage disposal may be used, if it is approved by the Department.

(2) Private sewage disposal systems shall comply with COMAR 26.04.02.

E. Water Supply. A nursing home shall be served by water from a safe public water supply, if available, as determined by the Department.

F. Approval of Private Water Supply.

(1) If a safe public water supply is not available, a private water supply may be used if it is approved by the Department.

(2) Private water systems shall comply with all federal, State, and local requirements.

G. Emergency Procedures. Emergency procedures shall be established and documented that enable the nursing home to provide water in all essential areas in the event of the loss of the normal water supply or if the nursing home would have to shelter in place during an emergency or disaster. These written procedures shall:

(1) Be a part of the nursing home's Emergency and Disaster Plan, in conformance with Regulation .40 of this chapter; and

(2) Describe the nursing home's plan to ensure that there is an adequate amount of safe drinking water for all residents and staff for a minimum of 72 hours.

H. Adequacy of Pressure.

(1) The water supply shall be adequate in quantity and delivered under sufficient pressure to satisfactorily serve equipment in the nursing home.

(2) A minimum pressure of 15 psi during demand period is required at top floor equipment.

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

(1) Resident use, the water temperature shall be between 100°F (38°C) and 120°F (49°C):

(a) Washing;

(b) Bathing; and

(c) Other personal use;

(2) Food preparation use, as referenced in COMAR 10.15.03; and

(3) Laundry use, as referenced in the 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings.

.44 Physical Plant — Heating and Cooling.

A. Unless otherwise indicated, all general requirements apply to both new construction and an existing nursing home.

B. Temperatures. A nursing home shall maintain a minimum design temperature of 75°F or 24°C for all occupied areas.

C. Heating System. A nursing home shall be equipped with a properly maintained and operational central heating system. The heating system shall be:

(1) Capable of maintaining 75°F or 24°C throughout the residents' section of the building with the outside temperature as prescribed in the Guidelines for Design and Construction of Residential Health, Care, and Support Facilities; and

(2) In compliance with NFPA 101 Life Safety Code, NFPA 99 Health Care Facilities Code, and other applicable codes, and all federal, State, and local codes.

D. Humidity. The humidity shall be controlled according to the guidelines prescribed in the Guidelines for Design and Construction of Residential Health, Care, and Support Facilities.

E. Auxiliary Heat. Appropriate provisions shall be made for emergency auxiliary heat by means of alternative sources of electric power, alternative fuels, or standby equipment.

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

G. Boiler rooms. Boiler rooms shall be provided with sufficient outdoor air to maintain combustion rates of equipment and to limit temperatures in working stations to 97°F or 36°C.

H. Air Conditioning.

(1) A nursing home shall be equipped with a properly maintained air conditioning system.

(2) The air conditioning system shall be in compliance with NFPA 101 Life Safety Code, NFPA 99 Health Care Facilities Code, and all federal, State, and local codes.

(3) In an existing structure, the nursing home shall comply with the regulations and building codes effective at the date of construction.

(4) In new construction or renovation, the nursing home shall comply with the regulations and building codes effective at the date of construction or renovation.

.45 Physical Plant — Ventilation.

A. Unless otherwise indicated, all general requirements apply to both new construction and an existing nursing home.

B. An existing nursing home shall provide for adequate ventilation through windows or mechanical means or a combination of both.

C. A new nursing home shall adhere to the requirements of this chapter.

D. Ventilation System Details.

(1) All air-supply and air-exhaust systems shall be mechanically operated.

(2) The ventilation rates shown in Table 1 under §D(10) of this regulation shall be considered the minimum acceptable rates and may not be construed as precluding the use of higher ventilation rates.

(3) All fans serving exhaust systems shall be located at the discharge end of the system.

(4) Outdoor air intakes shall be located:

(a) As far as practical but not less than 25 feet from:

(i) Exhaust outlets of ventilating systems;

(ii) Combustion equipment stacks;

(iii) Medical-surgical vacuum systems;

(iv) Plumbing vent stacks; or

(v) Areas that may collect vehicular exhaust and other noxious fumes; and

(b) As high as practical, so that the bottom of the outdoor air intake is:

(i) At least 6 feet above ground level; or

(ii) At least 3 feet above roof level.

(5) The ventilation systems shall be designed and balanced to provide the pressure relationships as shown in Table 1 under §D(10) of this regulation.

(6) The bottoms of ventilation openings may not be not less than 3 inches above the floor of any room.

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

(8) Filters.

(a) A central ventilation or air conditioning system shall be equipped with filters having efficiencies no less than those specified in Table 2 under §D(11) of this regulation.

(b) The filter bed shall be located upstream of the air conditioning equipment, unless a prefilter is employed.

(c) If a prefilter is employed, the prefilter shall be upstream of the equipment and the main filter bed may be located further downstream.

(d) A filter or filter efficiency shall comply with the standards of the Guidelines for Design and Construction of Residential Health, Care, and Support Facilities.

(e) A filter frame shall be durable and carefully dimensioned and shall have an airtight fit with the enclosing duct work.

(f) A joint between filter segments and the enclosing duct work shall be gasketed or sealed to provide a positive seal against air leakage.

(g) A manometer shall be installed across each filter bed serving central air systems.

(9) Air Ducts.

(a) Air-handling duct systems shall meet the requirements applicable to nursing homes cited in NFPA 99 Health Care Facilities Code.

(b) Fire and smoke dampers shall be constructed, located, and installed in accordance with the requirements of NFPA 101 Life Safety Code.

(c) Air ducts that pass through a required smoke barrier shall be provided with a smoke damper at the barrier.

(d) Smoke dampers shall activate by smoke detectors located in the ducts at the smoke barrier, or by the smoke detectors used to close smoke barrier doors.

(e) Smoke dampers shall be controlled to close automatically to prevent flow of smoke-laden air in either direction.

(f) Smoke dampers shall be equipped with automatic remote control reset devices, except that manual reopening will be permitted if smoke dampers are accessible.

(g) All devices shall be interlocked with the fire alarm system.

(10) Table 1. This table refers to the pressure relationships and ventilation of certain areas of a nursing home other than chronic disease hospitals.

Area Designation	Pressure Relationship To Adjacent Areas	Minimum Air Changes of Outdoor Air per Hour Supplied to Room	Minimum Total Air Changes per Hour Supplied to Room	All Air Exhausted Directly to Outdoors	Recirculated Within Room Units
(a) Resident Room	E	2	2	Optional	Optional
(b) Resident Area Corridor	E	2	4	Optional	Optional
(c) Examination and Treatment Room	E	2	6	Optional	Optional
(d) Physical Therapy	N	2	6	Optional	Optional
(e) Occupational Therapy	N	2	6	Optional	Optional
(f) Soiled Workroom or Soiled Holding	N	2	10	Yes	No
(g) Clean Workroom or Clean Holding	P	2	4	Optional	Optional
(h) Toilet Room	N	Optional	10	Yes	No
(i) Bathroom	N	Optional	10	Yes	No
(j) Janitor Closet(s)	N	Optional	10	Yes	No
(k) Sterilizer Equipment Room	N	Optional	10	Yes	No
(l) Linen and Trash Chute Room	N	Optional	10	Yes	No
(m) Food Preparation	E	2	10	Yes	No

Center					
(n) Warewashing Room	N	Optional	10	Yes	No
(o) Dietary Day Storage	E	Optional	10	Yes	No
(p) Laundry, General	E	2	10	Yes	No
(q) Soiled Linen Sorting and Storage	N	Optional	10	Yes	No
(r) Clean Linen Storage	P	2	2	Optional	Optional
Key: P = Positive, N = Negative, E = Equal					

(11) Table 2. This table refers to the filter efficiencies for central ventilation and air conditioning systems in a nursing home other than chronic disease hospitals.

Area Designation	Minimum Number of Filter Beds	Filter Efficiencies (Percent) Main Filter Bed
(a) Resident Care, Treatment, Diagnostic, and Related Areas. These areas may be reduced to 35 percent for all-outdoor air systems.	1	80
(b) Food Preparation Areas and Laundries.	1	80
(c) Administrative, Bulk Storage and Soiled Holding Areas.	1	25

(12) Exhaust Hoods. All hoods over cooking surfaces shall comply with the requirements as provided in COMAR 10.15.03.

.46 Physical Plant — Emergency Power.

A. Unless otherwise indicated, all general requirements apply to both new construction and an existing nursing home.

B. Emergency Electrical Power.

(1) The nursing home shall provide emergency electrical power.

(2) Emergency power for the purpose of egress lighting and protection shall be as required by NFPA 101 Life Safety Code.

(3) Other emergency lighting shall be as follows:

(a) Nursing station;

(b) Drug distribution station or unit dose storage;

(c) A lighted area for emergency telephone use;

(d) Boiler or mechanical room;

(e) Kitchen;

(f) Generator set location and switch gear location;

(g) Elevator, if operable on emergency power;

(h) Areas where life support equipment is used;

(i) If applicable, lighting for the common area of refuge; and

(j) If applicable, lighting in toilet rooms of the common area of refuge.

(4) Emergency power shall be provided for the:

(a) Nurses' call system;

(b) Duplex receptacles installed 50 feet apart in all corridors in resident areas or appropriately located duplex receptacles in the common area of refuge;

(c) Telephone service with at least one telephone available for incoming and outgoing calls;

(d) Fire pump;

(e) Sewerage pump and sump pump;

(f) Elevator, if required, for evacuation as referenced in NFPA 101 Life Safety Code;

(g) Heating equipment, if applicable, to maintain a minimum temperature of 71°F or 22°C in the common areas of refuge;

(h) Life support equipment;

(i) Nonflammable medical gas systems;

(j) Computer system, if applicable, to enable use of electronic medical records system; and

(k) Refrigerated medication storage.

(5) Common Area or Areas of Refuge.

(a) The nursing home shall provide a common area or areas of refuge in an emergency situation if all resident rooms, day rooms, and toilet rooms are not tied into the emergency generator to provide heat and cooling.

(b) The common area or areas of refuge:

(i) Shall be at least 30 square feet per bed, not including corridors;

(ii) May not include toilet rooms in the 30 square feet per bed; and

(iii) Shall maintain a minimum temperature of 71°F or 22°C and a maximum temperature of 81°F or 27°C.

(c) The nursing home shall provide heated toilet rooms adjacent to the common areas of refuge.

(d) The nursing home shall provide a Department-approved written plan that:

(i) Defines the specified area of refuge;

(ii) Outlines paths of egress from the common areas of refuge; and

(iii) Describes provisions for light, heat, food service, washing, and toileting residents.

(6) Emergency Power Source.

(a) The emergency power source shall be a generating set and prime mover located on the premises with automatic transfer.

(b) The emergency generator shall:

(i) In the event of failure of the normal electrical service, be activated immediately;

(ii) Come to full speed and load acceptance within 10 seconds;

(iii) Have a capacity of 48 hours of operation from fuel stored on-site; and

(iv) Be tested once a month, for at least 30 minutes under normal emergency nursing home connected load, and the test recorded in a permanent log book maintained for that purpose.

.47 Nursing Care Unit.

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

B. Common Space. The nursing home shall provide a living room for residents' use with a sufficient number of reading lamps, tables, and comfortable chairs or sofas.

C. Service Areas Required.

(1) Nurses' Work Area.

(a) The nurses' work area shall be located on the unit and within easy view of corridors outside of residents' rooms.

(b) The Department may specify the location and size of a nurses' work area which serves a nursing care unit exceeding 40 beds.

(2) Nursing Care Unit.

(a) A nursing care unit, regardless of size, including special care units, shall be equipped as described in this regulation.

(b) A nursing care unit bathroom shall include:

(i) A toilet, within the care unit, for the use of personnel; and

(ii) A hand-washing sink equipped with goose-neck spout, separate soap dispenser, and disposable paper towel dispenser.

(c) A nursing care unit's medicine shall be stored in accordance with the following procedures:

(i) Shall be stored in a cabinet with locks;

(ii) Schedule II drugs shall be kept in a separately locked, securely fixed box or drawer in the medicine storage cabinet under two locks, keyed differently;

(iii) The medicine storage and preparation area shall be illuminated with at least 100 foot-candles at the work counter;

(iv) The preparation area shall include a small sink set into the counter or with drain boards and a biological refrigerator; and

(v) The medicine storage cabinet, medicine preparation area, and biological refrigerator shall be under the direct visual control of the nursing or pharmacy staff.

(d) Nurses' call system.

(e) Charting desk and supplies.

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

(g) A nursing care unit shall have sufficient space and equipment for medical records so that personnel can function effectively and maintain easily accessible records for all residents.

(3) Medication Storage in Nursing Home.

(a) The storage facility shall provide for the conditions listed in §C(3)(b)—(g) of this regulation when prescribed.

(b) Cold — Any temperature at or below 46°F or 8°C. A refrigerator is a cold place in which the temperature is maintained thermostatically between 46°F and 59°F or 8°C and 15°C. A freezer is a cold place in which the temperature is maintained thermostatically between -4°F and -14°F or -20°C and -26°C.

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

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

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

(f) Excessive Heat — Any temperature above 104°F or 40°C.

(g) Protection from Freezing. The container label bears appropriate instructions to protect the product from freezing when freezing it may subject a product to:

(i) Loss of strength or potency;

(ii) Risk of breakage of the container; or

(iii) Destructive alteration of the dosage form.

(h) Storage under Non-specific Conditions. When no specific storage directions or limitations are provided in the individual monograph, the storage conditions shall include protection from moisture, freezing, and excessive heat.

(4) Space for Storage of Linen. Capacity shall be provided for storing of at least two complete linen changes per bed. Clean linen shall be stored separately from unclean items.

(5) Janitor Closet — New Construction.

(a) A nursing unit shall contain at least one janitor closet containing a floor receptor or service sink and storage space for housekeeping equipment and supplies.

(b) The janitor closet shall be equipped for hand washing.

(c) The janitor closet shall be connected to mechanically operated exhaust ventilation.

(d) The plumbing fixture for the utility or service sink within a janitor closet shall be provided with a back-flow prevention device.

(6) Utility Rooms.

(a) There shall be separate clean and soiled utility rooms in each nursing unit:

(i) Accessible to the resident area;

(ii) Each having separate entrances; and

(iii) No more than 120 feet to the most remote resident bedroom.

(b) The clean utility room shall contain:

(i) A small sink equipped with gooseneck spout and wrist blades;

(ii) Soap and individual paper towels in a dispenser;

(iii) Adequate storage and work counter space for storage and assembly of supplies for nursing procedures; and

(iv) Clean linen stored and transported in covered containers, closed linen carts, or rooms exclusively provided for this purpose.

(c) The soiled utility room shall contain:

(i) Work counter with sink, gooseneck faucet, and wrist blades;

(ii) A small sink equipped with soap and individual paper towels in a dispenser;

(iii) Space for waste receptacles and soiled linen receptacles; provision for storing and transporting soiled linen in covered leakproof containers;

(iv) Equipment to clean and sanitize bedpans, urinals, and basins; and

(v) Equipment for the disposal of liquid and semi-solid wastes and bodily fluids via the nursing home's sanitary sewer connection or on-site sewage disposal system.

(7) Culture Change Nursing Home. In a culture change nursing home, service areas shall be provided for resident care needs as approved by the Department. The culture change nursing home shall be required to have service areas that meet the specifications in this chapter for:

(a) Clean storage;

(b) Soiled holding;

(c) Laundry;

(d) Janitorial services; and

(e) Medication storage.

D. Drinking Fountains. One public drinking fountain or comparable equipment as preapproved by the Department shall be provided on each floor, usable from a wheelchair. Alternative means to provide drinking water to residents, staff, and the general public may be used as approved by the Department.

E. Automated External Defibrillator.

(1) A nursing home shall possess a functioning automated external defibrillator (AED).

(2) As of July 1, 2020, a nursing home shall install a functioning AED unit.

.48 Call Systems.

A. Call System.

(1) A nurse call system shall be installed and maintained in operating order in all nursing units.

(2) A call system shall be maintained in a manner that will provide visible and audible signal communication between nursing service personnel and residents.

(3) A call station shall provide readily accessible and detachable extension cords to each resident's bed in the residents' rooms at all times.

(4) A call system shall have a visible signal above the door of each resident's bedroom that shall be visible from all parts of the corridor.

(5) A call system shall provide visual lights at corridor intersections, in multi-corridor nursing units.

(6) A call system shall be provided in each resident's bathroom and bathing area in locations accessible to the residents.

(7) The call system shall enable residents in the rehabilitation area to summon rehabilitation staff.

(8) The nurses' call system shall require resetting at the station where the call originates.

B. Wireless Call Systems.

(1) A call system that uses wireless pagers or other wireless communication devices may be used as an alternative system.

(2) A wireless device shall:

(a) Be issued to all assigned direct care staff; and

(b) Receive signals originating from residents' bedrooms, bathrooms, bathing areas, and therapy areas.

(3) The use of an approved wireless call system shall eliminate the need to install call light indicators outside the residents' bedrooms, bathrooms, bathing areas, and therapy areas.

(4) A computer system with a monitor or other electronic display device may be installed to replace the call system annunciator, as long as it reveals the location where the signal originated and sounds an audible alert tone.Otherwise, a dedicated annunciator connected to the wireless call system will be needed.

(5) An electrically powered call system shall be connected to the emergency power supply.

(6) The sounding of the audible signal shall be continuous or intermittent until answered.

(7) The audible signal may not be turned off at the nursing station.

(8) The audible signal shall be loud enough to be heard at the nurses' station.

.49 Resident Bedroom in Nursing Home.

A. Unless otherwise indicated, all general requirements apply to both new construction and an existing nursing home unless a waiver has been granted by the Office of Health Care Quality in accordance with Regulation .03G of this chapter.

B. Bedroom Accommodations.

(1) Bedroom.

(a) A resident's room shall have direct access to an exit in accordance with the requirements applicable to nursing homes specified in NFPA 101 Life Safety Code.

(b) A room that opens into the kitchen may not be used as a resident bedroom.

(c) A room may not be used as a resident bedroom if it can only be reached by passing through a kitchen.

(d) Residents may not occupy rooms extending below the ground level.

(e) No more than four individuals may occupy a multiple occupancy bedroom.

(f) Residents' beds may not be located near radiators, registers, or sources of draft.

(g) Adequate storage space shall be provided in each bedroom to allow each resident to keep necessary items of clothing, including items that need to be hung.Adequate storage space shall be provided for residents' personal possessions, including the storage of seasonal clothing.

(h) All occupants of any bedroom shall be of the same sex, except in the case of a two-bed room occupied by:

(i) Siblings;

(ii) A parent and child;

(iii) A married couple; or

(iv) Consenting residents.

(2) Bedroom — New Construction. A nursing home shall provide cubicle curtains and tracks in multiple occupancy bedrooms between beds to ensure privacy of residents.

(3) Bedroom — Existing Construction. In an existing nursing home, curtains or screens shall be acceptable.

C. Floor and Window Space.

(1) Floors.

(a) A distance of at least 3 feet shall be maintained between each bed. Beds are to be placed so that all sides of the bed are at least 18 inches from heating units.

(b) The following shall be considered a minimum allowance of floor space:

(i) 100 square feet, single-bed room; and

(ii) 80 square feet, per bed, for multiple-bed rooms.

(c) The following floor areas may not be included in the calculation of floor space:

(i) Toilet rooms and bathing facilities;

(ii) Closets;

(iii) The floor area occupied by wardrobes, bureaus, or lockers, when permanently installed as part of walls or ceilings and as a permanent component of a bedroom;

(iv) HVAC equipment, including any steam, water, or electrical supply or return lines that may run parallel to the floor or interrupt the floor surface;

(v) Support columns, pipe chases, or other structures, whether free-standing or as an integral part of a wall; and

(vi) The arc of any doors that open into the room, excluding closet doors.

(d) The minimum horizontal dimensions of a bedroom shall be 10 feet to:

(i) Facilitate the placement of beds as required in Regulation .44 of this chapter; and

(ii) Maintain a minimum clearance of 3 feet at the foot of the bed.

(e) In an existing nursing home, the usable floor area for rooms having a bedroom shall have a finished ceiling height of 8 feet. For a bedroom that has sloping walls, only 50 percent of the floor area with a ceiling height between 4 feet and 7 feet, 6 inches, shall be credited, provided that at least 50 percent of the total area of the bedroom has a ceiling height of 8 feet.

(2) Windows.

(a) The window area within each bedroom shall be at least 10 square feet per bed. The window opening shall be at least 28 inches so that the total area equals 10 square feet per bed.This is to allow entry of fire fighters, removal of smoke, and emergency evacuation.

(b) The maximum height from the floor to the top of a window sill shall be 44 inches above the finished floor.

(c) A portable window air-conditioning unit may not block window space. The installation of a portable air-conditioning unit shall be approved by the:

(i) Local fire authorities; and

(ii) Department.

(d) If windows cannot be opened for ventilation, a central HVAC system shall be provided and maintained.

(e) If windows can be opened, but the nursing home has concern over the window being opened due to resident safety issues and elopement, the window sash may be restricted by hardware as approved by the Department.

D. Furnishings.

(1) Furnishings.

(a) The nursing home shall provide residents with their own bed. The bed shall be at least 36 inches wide and be substantially constructed. Rollaway type beds, cots, or folding beds may not be used.

(b) Bed.

(i) Each bed provided shall be in good repair, with a clean and comfortable standard size mattress and foundation.

(ii) To avoid injury to the resident, the mattress and foundation shall fit the bed.

(iii) Clean linen and a clean, comfortable pillow shall be provided. Extra pillows shall be available.

(c) Bedroom Furniture. A resident shall be provided with the following furnishings, which shall be convenient to the resident:

(i) Bedside stand with a drawer;

(ii) Towel hanger;

(iii) A comfortable chair;

(iv) A chest of drawers with at least one locking drawer;

(v) Enclosed space for hanging clothing;

(vi) A wall mirror in each room, unless contraindicated by physician's order; and

(vii) A bedside lamp, over-bed lamp, or other directional light source for resident reading and bedside care.

(d) Resident's Personal Furnishings.

(i) A nursing home shall develop policies and procedures to give residents the opportunity to use the resident's own furnishings as detailed in this chapter.

(ii) The nursing home shall make its resident's personal furnishing policies available for review by residents and the resident's representative.

(iii) These policies shall address the condition of the personal furnishings, presence of insects or vermin, and overall safety to ensure that the use of the resident's belongings does not create any safety or health issues.

(iv) Personal furnishings that are allowed shall be appropriate for the resident's use.

(e) Windows shall be provided with shades or draperies adequate to control glare and maintain privacy.

(f) Each living room for residents' use shall be provided with a sufficient number of reading lamps, tables, and comfortable chairs or sofas.

(2) Furnishings — New Construction. A bedroom shall be provided with a hand-washing sink with both hot and cold running water unless a toilet or bathroom facility with a sink is connected to the bedroom.

(3) Medication Storage Cabinets.

(a) Medication storage cabinets with locks shall be permitted for the storage of resident medications that do not require refrigeration within a resident bedroom.

(b) Controlled medications to be stored within medication storage cabinets in a resident's room shall be held within a separate compartment that is locked and inside of the larger medication storage cabinet in that room.

.50 Body-Holding Room.

A. Body-Holding Room — New Construction and Existing Nursing Home.

(1) A body-holding room shall be equipped with ventilation by mechanical means at the same rate and specifications as designed for soiled linen sorting and storage areas.

(2) A nursing home shall develop and implement a method for body-holding that minimizes the psychological effects on other residents.

B. Body-Holding Room — New Construction. A body-holding room shall be located to facilitate quiet and unobtrusive ingress and egress of bodies, convenient to the elevator and with an isolated exit.

C. Body-Holding Room — Existing Nursing Home. If a body-holding room is not provided, a holding area shall be designated that approximates the above conditions.

.51 Resident Bathroom Amenities.

A. Bathing.

(1) There shall be at least one separate room or compartment with a bathtub, shower, or other bathing device, as approved by the Department, for every 15 licensed beds.

(2) The compartment shall be large enough to accommodate:

(a) The resident;

(b) A caregiver; and

(c) A wheelchair, shower chair, or shower bed.

B. Toilets.

(1) For every eight beds, there shall be at least one toilet enclosed in a separate room or stall.

(2) Each floor shall have at least one toilet room large enough to:

(a) Accommodate:

(i) The resident;

(ii) A wheelchair; and

(iii) A caregiver; and

(b) Permit toilet assistance or training.

C. Sinks.

(1) For every four licensed beds, there shall be at least one hand-washing sink.

(2) For hand-washing purposes, there shall be a towel dispenser and a supply of paper towels and soap dispenser adjacent to each sink.

.52 Equipment and Supplies for Bedside Care and Therapy.

A. Needs of Residents.

(1) There shall be sufficient equipment to meet the needs of the residents admitted.

(2) The administrator shall obtain specific items required for individual cases where requested by the attending physician or medical director.

(3) The Department may require that the nursing home have specific types of equipment based on the needs of the residents.

(4) A nursing home shall establish and enforce a written preventive maintenance program to ensure that all resident care and therapy equipment is maintained in safe operating condition.

B. Use of Hot Packs, Ice Packs, and Other Therapeutic Medical Devices.

(1) Covers shall be placed on hot packs, ice packs and other temperature-related therapeutic medical devices before they are placed in a bed or on a resident.

(2) The temperatures in the building, hot packs, and therapeutic equipment may not exceed 120°F or 49°C.

(3) The use of hot and cold medical devices shall be:

(a) Consistent with manufacturer' guidelines and nursing home policies; and

(b) Maintained and applied by trained staff.

.53 Rehabilitation Facilities — Space and Equipment.

A. Unless otherwise indicated, all general requirements apply to both new construction and an existing nursing home.

B. General Requirements.

(1) Space.

(a) A nursing home shall provide adequate space to:

(i) Receive, examine, and treat residents;

(ii) Store supplies and equipment, including wheelchairs and stretchers; and

(iii) Provide office space for the employed personnel to work.

(b) A nursing home shall allot 75 square feet for treatment area per resident, based on peak treatment schedules.

(c) A nursing home shall plan and arrange space for shared use by physical therapy and occupational therapy staff and residents, if scheduling permits.

(d) A nursing home may distribute space in the following manner:

(i) Storage space shall comprise at least 10 percent of the area designated for exercise and rehabilitation; and

(ii) Office space shall be at least 110 square feet for one therapist, or 85 square feet per therapist if there are two or more.

(2) Equipment.

(a) Equipment shall allow for providing safe and effective resident care.

(b) All electrical equipment shall be calibrated according to the manufacturer's guidelines and shall be serviced periodically as part of a preventive maintenance program. A sticker bearing the date of the most current inspection shall be affixed on each piece of equipment.

(c) All electrical equipment shall be tested periodically for proper grounding, current leakage, and calibration where appropriate.

(d) The operator's instruction manual shall be available in a designated location or accessible electronically at all times.

(e) All flammables shall be stored in compliance with NFPA 99 Health Care Facilities.

(f) Adequate exhaust ventilation shall be provided when using vaporous materials or pollutants.

(3) Toilet Facilities in Rehabilitation Area — New Construction.

(a) A nursing home with rehabilitation areas shall provide a hand-washing sink and toilet which meet Guidelines for Design and Construction of Residential Health, Care, and Support Facilities standards for residents who use a wheelchair.

(b) The nursing home shall be readily accessible to the residents receiving rehabilitative services.

(c) Toilets and bathing rooms within a rehabilitation area shall be equipped with a nurse call system.

.54 Dayroom and Dining Area.

A. General Requirements. Resident Dining, Occupational Therapy, and Activities Program. The nursing home shall provide one or more attractively furnished areas of adequate size for resident dining, occupational therapy, and social activities. Activities space shall be of adequate size to meet the needs of the residents and shall be located on each floor occupied by residents.

B. Dining Area.

(1) A nursing home shall provide dining areas large enough to accommodate all residents who eat there at the same time.

(2) There shall be an allowance of at least 12 square feet per resident. This allowance shall be substantially increased proportionate to the number of residents who use a wheelchair.

(3) The height of tables provided in dining areas shall accommodate each resident using a wheelchair.

C. Dayroom Area. Dayroom areas shall be provided that are:

(1) Adequate for the residents located on each nursing care unit; and

(2) Located convenient to the residents' bedrooms.

D. Multi-purpose Room.

(1) The nursing home shall provide a multi-purpose room for dining, occupational therapy, physical therapy, and social activities. There shall be sufficient space to accommodate all activities without interfering with each other.

(2) The nursing home shall set aside areas for residents' dining and recreation that total at least 30 square feet per licensed bed for the first 100 beds, plus 27 square feet per licensed bed for all beds in excess of 100.

(3) Areas that meet this requirement may include:

(a) Reception areas;

(b) Lobbies, portion not required for egress per NFPA 101 Life Safety Code, as are applicable to nursing homes;

(c) Hair care;

(d) Salon rooms;

(e) Resident gift shops;

(f) Theater;

(g) Auditorium;

(h) Spiritual worship;

(i) Meditation areas;

(j) Dayrooms;

(k) Dining areas;

(l) Libraries; and

(m) No more than 50 percent of the floor area of all occupational therapy and physical therapy areas, and other areas as approved by the Department.

.55 Dietetic Service Area.

A. General Requirements. Unless otherwise indicated, all general requirements apply to both new construction and an existing nursing home.

B. Food Service Department.

(1) The size and location of the food service area shall comply with COMAR 10.15.03.

(2) A catered or satellite system shall be covered by a contract approved by the Department.

(3) The vendor providing the food shall have a valid food service permit.

C. Outside Service Entrance. A convenient outside service entrance shall exist to facilitate receiving food supplies and the disposal of waste.

D. Restriction — Entry to Kitchen or Serving Pantry. A toilet room or sleeping room may not open directly into any kitchen or serving pantry.

E. Limitations on Use of Kitchen. The kitchen may not be used as a passageway. It shall be used for no other purpose than activities connected with food service.

F. Janitor Closet or Service Area.

(1) Janitor Closet — New Construction. A janitor closet or service alcove for the exclusive use of food service areas shall be provided in, or adjacent to, the dietetic service department.

(2) The janitor closet or service alcove shall be:

(a) Equipped with:

(i) A utility sink;

(ii) Storage shelves; and

(iii) A rack for hanging brooms and mops; and

(b) Connected to mechanically operated exhaust ventilation.

(3) The plumbing fixture for the utility sink within a janitor's closet shall be provided with an approved back-flow prevention device.

G. Space.

(1) There shall be sufficient floor space in the food service department to permit all activities to function efficiently without overcrowding or increasing the risk for cross-contamination of food or equipment from soiled surfaces.

(2) Minimum Space Requirements — New Construction.

Homes' Licensed Capacity for Residents	*Minimum Space*
(a) 2 to 10	120 square feet.
(b) 11 to 35	132 square feet plus 12 square feet per licensed bed in excess of 11.
(c) 36 to 100	430 square feet plus 10 square feet per licensed bed in excess of 36.
(d) over 100	1,070 square feet plus 8 square feet per licensed bed in excess of 100.

(3) Space — Existing Nursing Home.

(a) A nursing home that holds full licensure as of the adoption date of these regulations shall be considered to have an adequate size dietetic service department.

(b) Renovations of all kitchens shall be approved by the Department, which will consider modification of the minimum space requirement based on space available, costs, and type of service.

(4) Aisle space between working areas shall be at least 3 feet, and aisle space for main traffic shall be at least 5 feet wide.

(5) Ceiling height shall be at least 9 feet.

(6) If the licensed capacity of a nursing home is increased, or if meals are provided to anyone outside of the nursing home from the food service area of the nursing home, the nursing home shall provide an additional food service area in accordance with this chapter. The additional food service area required when meals are provided to anyone outside of the nursing home is to be calculated by using the total number of individuals to whom meals are provided.

(7) The kitchen space requirement as described in this regulation does not apply to occasional special functions such as picnics or dinners for residents, volunteers, families, or community groups as long as the nursing home certifies to the Department that providing meals for a special function will not adversely affect or detract from the timely provision of meals to the nursing home's residents.

H. Floor Pantries — New Construction.

(1) There shall be at least one food service floor pantry per nursing care unit.

(2) This area shall be of sufficient size to accommodate the equipment required for food preparation and service.

(3) The equipment provided in food service floor pantries shall comply with the requirements of the local health department.

(4) A food service floor pantry shall include the following:

(a) Refrigerator;

(b) Cabinets for dry storage and supplies;

(c) Work space;

(d) Sink for purposes other than hand-washing;

(e) Hand-washing sink with soap dispenser and disposable paper towel dispenser; and

(f) Except for trays that are assembled in the main kitchen and then distributed to the nursing care units, equipment to hold hot food if bulk foods are plated and served to the residents on the nursing care unit.

(5) A food service floor pantry shall include the following additional equipment:

(a) Toaster;

(b) Ice-making machine or ice-storage container;

(c) Work space for tray preparation;

(d) Equipment to deliver completed trays;

(e) Three-compartment sanitizing sink or dishwasher;

(f) Cabinet for dry storage, supplies, and kitchenware; and

(g) Storage for trays, tableware, flatware, and utensils.

I. Equipment for Food Preparation and Distributions.

(1) Adequate equipment for preparation, serving, and distribution of food shall be provided.

(2) A dumbwaiter, elevator, or ramp shall be provided in a nursing home of more than one story where more than eight residents above or below the kitchen level receive bedside tray service.

(3) Equipment to protect food from dust or contamination and to maintain food at proper temperature shall be provided to transport food to the residents.

J. Dry Food Storage.

(1) Food Storage Space.

(a) Adequate space shall be provided to store food supplies.

(b) The amount of storage space needed to store food depends on the frequency of deliveries.

(c) It is recommended that 2 square feet per resident be provided and that the dry food storage area be located within easy access to the receiving area and the kitchen.

(2) The storeroom shall be cool and well-ventilated.

(3) All food supplies shall be stored off the floor and away from the wall to allow for cleaning.

K. Refrigerated Storage.

(1) Adequate refrigerated storage, refrigerators, and frozen food storage cabinets shall be provided and regulated to maintain temperatures prescribed in COMAR 10.15.03.

(2) Food in storage shall be arranged so that new food items are stored behind old food items.

(3) The oldest foods shall be used first, known as the first in, first out method.

L. Mobile Food Carts.

(1) All policies and procedures for the mobile food cart shall be approved by the Department and the nursing home's local health department before implementation.

(2) Policies and procedures shall address, at a minimum the following:

(a) Identify how many staff members will assist with serving food items, pushing the mobile cart, and delivering meals to the residents;

(b) Ensure proper food protection on three sides to protect the food;

(c) Maintain proper temperature control, hot food at a minimum of 135°F and cold food maintained at a maximum of 41°F;

(d) Record of temperatures before serving meals on each individual unit;

(e) Ensure proper food temperatures; and

(f) Hand washing.

(3) The hand washing policy and procedures referenced in §L(2)(f) of this regulation shall include the following:

(a) Use of a hand sanitizer in lieu of proper hand washing is not permitted;

(b) Bare hands may not have direct contact with ready-to-eat food;

(c) Hand washing shall be done before starting meal service on each individual unit;

(d) When and at what location hand washing will be done;

(e) Hand washing may not be done in resident rooms;

(f) Access to a hand washing sink may not require the opening of a door;

(g) The hand washing sink shall be in a central, unobstructed location;

(h) Mobile hand sinks are acceptable as long as a written procedure to meet sanitation requirements is developed;

(i) The hand sink shall be supplied with hot and cold water under pressure;

(j) The unit shall be supplied with adequate waste containers to hold dirty water until dumping is done; and

(k) The written procedure shall include the disposal of the dirty water.

.56 Administrative Areas.

A. Unless otherwise indicated, all general requirements apply to both new construction and an existing nursing home.

B. Administrative Areas — New Construction.

(1) A nursing home shall provide a separate room or rooms for the administrator and administrative support staff. Sufficient areas shall be provided to accommodate all necessary office furniture, files, and other equipment and enable the safe storage of residents' valuables.

(2) In new construction, separate locker rooms and a toilet facility shall be provided for male and female employees in each nursing home.

C. Administrative Areas — Existing Nursing Homes.

(1) The nursing home shall provide an administrative area that is suitable for conducting business or discussing problems privately with the resident's representative.

(2) The nursing home shall provide a sufficient number of lockers that can be locked securely for all employees working at any one time, and shall provide for the employee use of toilet facilities.

D. Lobby Area — New Nursing Home. A nursing home shall provide a lobby area that shall have:

(1) Public toilets for both sexes, either separate or unisex, located conveniently to this area;

(2) Access to telephone; and

(3) Drinking fountains or other drinking water dispensers that meet Guidelines for Design and Construction of Residential Health, Care, and Support Facilities.

E. Employee Facilities — New Construction. In new construction, separate locker rooms and toilet facilities shall be provided for male and female employees in each facility.

F. Employee Facilities — Existing Facilities. An existing nursing home shall:

(1) Have a sufficient number of lockers that can be locked securely for all employees working at any one time; and

(2) Provide for the employee use of toilet facilities at a convenient location.

.57 Housekeeping Services, Pest Control, and Laundry.

A. General Requirements. Unless otherwise indicated, all general requirements apply to both new construction and an existing nursing home.

B. Staff. Sufficient housekeeping and maintenance personnel shall be employed to maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner.

C. Cleanliness and Maintenance.

(1) The building and all its parts and facilities shall be kept in good repair, neat, and attractive. The safety and comfort of the residents shall be the primary consideration.

(2) All walls, floors, ceilings, windows, and fixtures shall be kept clean. Interior walls and floors shall be of a type to allow frequent and easy cleaning.

(3) The nursing home shall be kept free of unnecessary accumulations of personal possessions, boxes, trunks, suitcases, papers, unused furniture, bed clothing, linens, bric-a-brac, and similar items.

(4) Storage areas shall be:

(a) Kept clean and orderly; and

(b) Readily accessible for:

(i) Housekeeping;

(ii) Maintenance; and

(iii) Pest control servicing.

(5) The grounds shall be kept clean, neat, attractive, and free of hazards.

(6) Pest Control. The nursing home shall:

(a) Be maintained free of insects and rodents by operation of an active pest-control program, either by use of maintenance personnel or by contract with a pest-control company;

(b) Use and store toxic and flammable insecticides and rodenticides with care;

(c) Ensure that usage of toxic and flammable insecticides and rodenticides conforms to the U.S. Environmental Protection Administration and Maryland Department of Agriculture requirements;

(d) Be protected to prevent the entry and harborage of rodents and insects;

(e) Install and effectively maintain:

(i) Screen doors that fit tightly when closed;

(ii) Easily adjusted closely fitted window screens;

(iii) Rat-proofing devices; or

(iv) Other approved deterrents; and

(f) Effectively protect all openings to the outside against the entry of insects by:

(i) Closed doors;

(ii) Closed windows; or

(iii) Other means.

(7) Laundry Services.

(a) A nursing home shall provide laundry service, whether on-site or off-site.

(b) Laundry service shall be provided to meet the residents' needs.

(c) All laundry shall be processed and handled in a manner that prevents the spread of infections. Staff working in laundry shall be given personal protective equipment, including:

(i) Disposable gloves;

(ii) Masks; and

(iii) Body coverings.

(d) All laundry shall be processed through the use of sufficiently hot water, chemical agents, or a combination of the both, to remove or destroy infectious biological materials.

(e) Clean and Soiled Areas.

(i) There shall be a physical separation between the clean and soiled areas.

(ii) The soiled area shall allow for sorting and washing soiled laundry.

(iii) The clean area shall allow for drying and folding of clean laundry.

(iv) All soiled areas within a laundry shall be connected to mechanically operated exhaust ventilation.

(f) The system provided in laundries may not allow the spread of airborne contaminants to other parts of the nursing home that are occupied by residents, staff not working in the laundry, and the general public.

(g) The plumbing fixtures for all water supply connections to washing machines and the plumbing fixtures for all utility sinks shall have an integrated atmospheric vacuum breaker or other approved back-flow prevention devices.

.58 Resident Care Management System.

A. Each comprehensive care facility and extended care facility shall establish and maintain a resident care management system.

B. The resident care management system shall consist of three related components:

(1) Resident status assessment and data gathering;

(2) Care planning; and

(3) Actions in response to care plan approaches.

.59 Resident Status Assessment.

A. A nursing home shall use the following forms and procedures for resident assessment as described in the CMS Manual System, Pub. 100-07 State Operations Provider Certification and in the CMS Long-term Care Facility Resident Assessment Instrument 3.0 User's Manual:

(1) The Minimum Data Set (MDS) version as determined by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, in Transmittal No. 22, referenced in §B of this regulation.

(2) MDS Care Area Assessment process; and

(3) Care plans.

B. The nursing home shall complete all assessments in accordance with the provisions of 42 CFR §483.20, as amended.

C. A nursing home certified for participation in Medicare or Medicaid shall complete and electronically submit the assessment to the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. The assessment shall:

(1) Use a standard record layout format;

(2) Use a data dictionary as identified by the automated data processing requirements; and

(3) Pass standardized edits as defined by CMS and the State.

D. A federally certified nursing home shall:

(1) Encode assessment data as specified in the CMS Long-term Care Facility Resident Assessment Instrument 3.0 User's Manual; and

(2) Transmit assessment data as specified in the CMS Long-term Care Facility Resident Assessment Instrument 3.0 User's Manual except as excluded in §E of this regulation.

E. A nursing home licensed as a nursing home but not certified for participation in the Medicare or Medicaid Program shall comply with the CMS Manual System, Pub. 100-07 State Operations Provider Certification, and with RAI instructions in the CMS Long-term Care Facility Resident Assessment Instrument 3.0 User's Manual, except that data may not be submitted electronically to the Department.

.60 Care Planning.

A. An interdisciplinary team shall complete or revise as necessary a resident-specific care plan for each resident within 7 calendar days following completion of assessments, including:

(1) Admission assessment;

(2) Annual assessment;

(3) Quarterly assessment; and

(4) Significant change in the resident's condition.

B. Care Plan Meeting. The nursing home shall, with the resident's consent:

(1) Give an interested and appropriate family member or resident's representative 7 calendar days advance notice, in writing, of the location, date, and time of a care planning conference for a resident;

(2) Strive to accommodate the schedules of invited family members and resident's representatives when scheduling care plan meetings; and

(3) Include an invitation for the family member or resident's representative to attend the conference.

C. The nursing home shall hold the care planning conference not later than 7 calendar days after completing the assessment, but may hold the conference sooner if agreed to by the resident, a family member, or a resident's representative.

D. Organization of Care Plan.

(1) Resident's problems and needs shall be identified, based upon the interdisciplinary assessment. The care plan shall address all of the resident's special care requirements necessary to improve or maintain the resident's status. The interdisciplinary team shall incorporate resident input into the care plan.

(2) The team shall establish goals for each problem or need identified, or a combination thereof. The goals shall be realistic, practical, and tailored to the resident's needs. Goal outcomes shall be measurable in time or degree, or both.

(3) Approaches to accomplishing each goal shall be established. Approaches shall indicate the work to be done, who is to do it, and how frequently it is to be done.

E. Disciplines shall update the care plans as the resident's assessment warrants, but not less than quarterly.

F. Availability of Resident Care Plan. Resident care plans shall be readily available for use by all health care personnel.

.61 Skin Record.

A. The facility shall establish a skin care record documenting skin, hair, and nail condition on admission, if any abnormal conditions exist.

B. The staff shall document progress of the condition or conditions weekly until the condition or conditions have healed.

C. At any time that a skin condition persists for more than 7 days, staff shall add the condition to the skin record.

.62 Geriatric Nursing Assistant Training Program.

A. Nursing Home Responsibilities.

(1) A nursing home shall conduct or arrange a geriatric nursing assistant training program for unlicensed personnel assigned to direct resident care duties. The Maryland Board of Nursing shall approve the geriatric nursing assistant training program curriculum.

(2) A nursing home may not employ an individual as a geriatric nursing assistant until the individual has successfully completed a competency evaluation approved by the Maryland Board of Nursing.

(3) A geriatric nursing assistant is deemed to satisfy the requirements of this chapter if that individual has successfully completed a training program approved by the State before July 1, 1990, or has been "grandfathered" under previous regulations.

(4) Other persons hired as geriatric nursing assistants shall complete an approved geriatric nursing assistant training program within 120 days of employment.

(5) The nursing home shall:

(a) Record the satisfactory completion of the program in each employee's personnel record; and

(b) Give the employee a certificate signed by the program's teacher or trainer as evidence of completion of the program.

B. Course Structure.

(1) The geriatric nursing assistant training program shall consist of 75 hours or more, and include at least 37.5 hours of classroom instruction and at least 37.5 hours of supervised clinical experience in long-term care.

(2) The course content shall adhere to the geriatric nursing assistant training program curriculum approved by the Maryland Board of Nursing.

.63 Paid Feeding Assistants.

A. A facility may use a paid feeding assistant who has successfully completed a State-approved training course as described in §E of this regulation.

B. Supervision.

(1) A paid feeding assistant shall work under the supervision of a licensed nurse.

(2) In an emergency, when the resident is fed in the resident's room, a paid feeding assistant shall use the resident call system to call a supervisory nurse for help.

C. A nursing home that uses a paid feeding assistant shall ensure that the paid feeding assistant feeds only residents who do not have complicated feeding conditions including, but not limited to:

(1) Difficulty swallowing;

(2) Choking;

(3) Recurrent lung aspiration; or

(4) Tube or parenteral intravenous feedings.

D. Protocol. The nursing home shall develop a protocol for selecting residents who are appropriate for feeding by a paid feeding assistant. The nursing home shall select eligible residents based on the:

(1) Charge nurse's current assessment of the resident;

(2) The resident's latest Minimum Data Set (MDS) assessment; and

(3) The resident's plan of care.

E. State-Approved Training. A State-approved training course for paid feeding assistants shall consist of at least 8 hours of training that includes:

(1) Feeding techniques;

(2) Assistance with feeding and hydration;

(3) Communication and interpersonal skills;

(4) Appropriate responses to resident behavior;

(5) Safety and emergency procedures, including the Heimlich maneuver;

(6) Infection control;

(7) Resident rights;

(8) Recognizing changes in a resident's behavior that are inconsistent with the resident's normal behavior and the importance of reporting these changes to a supervisory nurse; and

(9) Successful completion of a two-part test that includes a:

(a) Written test with a passing score of 80 percent; and

(b) Demonstration of proper feeding skills performed on a resident while being observed.

F. The feeding assistant training may be taught by a:

(1) Registered nurse and supplementary professional instructors;

(2) Licensed dietitian-nutritionist;

(3) Licensed physical therapist;

(4) Licensed speech therapist; or

(5) Licensed occupational therapist.

G. The facility shall maintain a record of all paid feeding assistants who have successfully completed a feeding assistance course.

.64 Quality Assurance Program.

A. A nursing home shall establish an effective quality assurance program that includes components described in this regulation and Regulation .65 of this chapter.

B. The nursing home shall appoint a qualified individual to manage quality assurance activities within the nursing facility.

C. The nursing home shall establish a quality assurance committee that includes at least:

(1) The nursing home director of nursing;

(2) The nursing home administrator;

(3) A social worker;

(4) The nursing home medical director;

(5) A dietitian-nutritionist; and

(6) A geriatric nursing assistant at the nursing home.

D. The Quality Assurance Committee. The quality assurance committee shall:

(1) Designate an individual to oversee committee activities;

(2) Meet monthly to carry out quality assurance activities;

(3) Help develop and approve the nursing home's quality assurance plan;

(4) Submit the quality assurance plan to the Department's Office of Health Care Quality at the time of initial application for licensure;

(5) Submit any changes to the quality assurance plan to the Office of Health Care Quality within 30 days of the changes;

(6) Review and approve the facility's quality assurance plan at least yearly; and

(7) Prepare monthly reports for the ombudsman, family council, and residents' council.

E. Quality Assurance Records. For the purposes of ensuring implementation and effectiveness of the quality assurance program, the facility shall make quality assurance records and documents available to the Office of Health Care Quality.

F. Quality Assurance Committee — Non-members. Anyone not on the committee shall be informed of how to present and submit concerns to:

(1) The committee;

(2) A member of the resident council; or

(3) A member of the family council if one exists.

.65 Quality Assurance Plan.

A. The nursing home's quality assurance committee shall develop and implement a quality assurance plan that includes procedures for:

(1) Concurrent review;

(2) Ongoing monitoring;

(3) Resident complaints;

(4) Accidents and incidents; and

(5) Abuse and neglect.

B. Concurrent Review. The quality assurance plan shall include:

(1) The procedures for conducting concurrent review of each resident including:

(a) Criteria to determine any change in a resident's condition;

(b) A method to document the concurrent review; and

(c) Identification of the licensed nurse or nurses conducting the concurrent review;

(2) The procedures to evaluate clinical data for any resident with a change in condition including at least:

(a) Medications;

(b) Laboratory values;

(c) Intake and output;

(d) Skin breakdown;

(e) Noted weights;

(f) Appetite;

(g) Injuries resulting from accidents or incidents; and

(h) Any other relevant parameters that may affect the resident's physical or mental status;

(3) Procedures to take action when there is a change in the resident's condition, including:

(a) Communicating changes to the director of nursing or the resident's attending physician; and

(b) Changing the resident's plan of care as necessary; and

(4) Procedure for referring data to the quality assurance committee, when appropriate.

C. Ongoing Monitoring. The quality assurance plan shall include:

(1) A description of the measurable criteria for ongoing monitoring of all aspects of resident care including:

(a) Medication administration;

(b) Prevention of pressure ulcers, dehydration, and malnutrition;

(c) Nutritional status and weight loss or weight gain;

(d) Accidents and injuries;

(e) Unexpected death; and

(f) Changes in physical or mental status;

(2) The methodology for collecting data;

(3) The methodology for evaluating and analyzing data to determine trends and patterns;

(4) A description of the thresholds and performance parameters that represent acceptable care for the measured criteria;

(5) Time frames for referral to the quality assurance committee;

(6) A description of the plan for follow-up to determine effectiveness of the recommendations; and

(7) A description of how the quality assurance activities will be documented.

D. Resident Complaints. The quality assurance plan shall include:

(1) A description of a complaint process that effectively addresses resident and family concerns including:

(a) The designated person or persons and their phone numbers to receive complaints and concerns;

(b) The method to be used to acknowledge complaints received; and

(c) The time frames for investigating complaints, depending on the nature or seriousness of the complaint;

(2) A description of a logging system that will be used including the:

(a) Name of the complainant;

(b) Date the complaint was received;

(c) Nature of the complaint; and

(d) Date that the complainant was notified of the disposition or resolution of the complaint; and

(3) The procedures for:

(a) Notifying residents of their right to file a complaint with the Office of Health Care Quality;

(b) Informing residents, families, or guardians of the complaint process upon admission; and

(c) Posting the complaint process or making it available without the need to request it.

E. Accidents and Injuries. The quality assurance plan shall include:

(1) A definition of accident and injury that is appropriate to the type of resident served by the nursing home;

(2) A description of the process for reporting accidents and injuries including:

(a) Who shall report incidents;

(b) The time frame for reporting incidents; and

(c) The procedure for reporting incidents;

(3) A policy statement that ensures that incidents can be reported without fear of reprisal;

(4) A description of how internal investigations of accidents and injuries will be handled including:

(a) Assessment of any injury;

(b) Interview of the resident, staff, and any witnesses;

(c) Review of any relevant records including the resident's medical records, discharge summary, hospital records, etc.; and

(d) Time frames for conducting the investigation;

(5) A description of the process for notifying a family or guardian about the incident;

(6) A description of the process for the ongoing evaluation of patterns and trends in accidents and injuries; and

(7) A description of how relevant information will be referred to the quality assurance committee.

F. Abuse and Neglect. The quality assurance plan shall include:

(1) The process for implementing COMAR 10.07.09.15 concerning abuse of residents;

(2) A description of the process for providing immediate notification to the family, guardian, or responsible party about the incident;

(3) A description of the process for the ongoing evaluation of validated incidents of abuse and neglect to determine patterns and trends; and

(4) A description of how relevant information will be referred to the quality assurance committee.

.66 Relocation of Residents.

A. The facility shall develop and implement a written plan to provide for the smooth and orderly transfer of residents if the facility closes.

B. The plan for relocation shall include:

(1) A description of how residents, families, or guardians will be notified and by whom;

(2) Sample letters and other documents that will be used during a closure;

(3) Procedures for notifying Medicaid and other payment sources;

(4) Procedures for notifying the Office of Health Care Quality; and

(5) A mechanism to ensure the safe and orderly transfer of residents that takes into account:

(a) Roommates, medical care, religious affiliation, geographical location and payer source;

(b) Proper assessment and identification of any special needs;

(c) Transfer of medical information and records; and

(d) Transfer of personal property.

.67 Posting of Staffing.

A. A nursing home shall post a notice on each floor or unit of the nursing home, for each shift, a notice that gives the ratio of licensed and unlicensed staff to residents.

B. The posting on each floor shall include:

(1) Names of the staff members on duty and the room numbers of the residents to whom each is assigned;

(2) Name of the charge nurse or person who is in charge of the unit;

(3) If the person in charge is not a registered nurse, the name of the registered nurse responsible for the unit; and

(4) Name of the medicine aide or person responsible for medication administration.

C. The posting shall be on a form provided or approved by the Department.

D. A record of the posting shall be retained for 1 year.

.68 Sanctions.

A. If a deficiency exists, the Department, in addition to the sanctions set forth in this regulation and Regulations .67—.74 of this chapter, may:

(1) Restrict the number of residents the nursing facility may admit in accordance with Health-General Article, §19-328, Annotated Code of Maryland;

(2) Require the establishment of an escrow account in accordance with Health-General Article, §19-362, Annotated Code of Maryland;

(3) Direct the licensee to correct the deficiencies in a specific manner or within a specific time frame, or both, to protect the health and welfare of residents;

(4) Enter into an agreement with the licensee establishing certain conditions for continued operation, including time limits for compliance; and

(5) In accordance with Health-General Article, §19-1405, Annotated Code of Maryland, appoint an independent State monitor who is qualified on the basis of education and experience to oversee correction of the deficiencies.

B. State Monitor.

(1) The duties of the State monitor shall be specified in a written agreement between the Department and the State monitor and shall include but are not limited to:

(a) Conducting periodic on-site inspections to assess a nursing facility's compliance with State and federal regulations;

(b) Making recommendations to achieve compliance with State and federal regulations; and

(c) Issuing written reports to the Department and the nursing home, detailing the findings of the on-site inspections and the status of requirements and recommendations for the nursing home to achieve compliance.

(2) The State monitor shall function for a period of time specified by the Department. The facility may request rescission or modification of the duration of the State monitor's appointment at intervals of not less than 120 days from the date of appointment.

(3) The State monitor may not be an employee of the Department.

(4) The State monitor's salary shall be:

(a) Paid directly by the nursing facility; and

(b) At least equivalent to the prevailing salary paid by nursing facilities for an individual with similar education and experience.

C. If the Secretary determines that the licensee has violated a condition or requirement of an imposed sanction, the Secretary may revoke the license as permitted by applicable law.

D. A licensee that disagrees with the imposition of a sanction under §A(1) or (5) of this regulation may appeal the Secretary's action by filing a request for a hearing in accordance with Regulation .78 of this chapter. A licensee that disagrees with the imposition of a sanction under §A(2) of this regulation may appeal the Secretary's action in accordance with Health-General Article, §§19-364 and 19-367, Annotated Code of Maryland.

.69 Mandated Staffing Pattern.

A. When the Department determines that a deficiency or deficiencies exist, the Department shall notify the nursing facility of the deficiency or deficiencies and may either:

(1) Mandate a staffing pattern which specifies the number of personnel or personnel qualifications, or both; or

(2) Permit the facility the opportunity to correct the deficiencies by a specific date.

B. If the facility does not correct the deficiency or deficiencies, the Department has the authority to specify the number of personnel or personnel qualifications, or both.

C. The facility shall comply with the Department's mandated staffing pattern and notify the Department, in writing, when the staffing pattern has been implemented.

D. A mandated staffing pattern shall be in effect for the period of time specified by the Department. A facility may request rescission or modification of the staffing pattern at intervals of not less than 60 days from the date of imposition of the staffing pattern.

E. A facility has the right to appeal a mandated staffing pattern in accordance with State Government Article, Title 10, Subtitle 2, Annotated Code of Maryland. However, the mandated staffing pattern shall be maintained during the pendency of the appeal.

.70 Civil Money Penalties — Imposition.

A. A civil money penalty may be imposed when:

(1) A deficiency exists; or

(2) An ongoing pattern of deficiencies exist in a nursing facility.

B. In determining whether a civil money penalty is to be imposed, the Department shall consider the following factors:

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

(2) The extent to which the deficiency or deficiencies are part of an ongoing pattern during the preceding 24 months;

(3) The degree of risk to the health, life, or safety of the residents of the nursing facility caused by the deficiency or deficiencies;

(4) The efforts made by, and the ability of, the nursing facility to correct the deficiency or deficiencies;

(5) A nursing facility's prior history of compliance in general and specifically with reference to the cited deficiencies; and

(6) Such other factors as justice may require.

C. When the Department determines that a deficiency or an ongoing pattern of deficiencies exists, the Department shall notify the nursing facility of the deficiency or deficiencies and may:

(1) Impose a per day civil money penalty until sustained compliance has been achieved;

(2) Permit the facility the opportunity to correct the deficiencies by a specific date; or

(3) Impose a per instance civil money penalty for each instance of violation.

D. When the Department permits a facility the opportunity to correct the deficiencies by a specific date, and the facility fails to comply with this requirement, the Department may impose a per day civil money penalty for each day of violation until correction of the deficiency or deficiencies has been verified and sustained compliance has been maintained.

E. When a civil money penalty is imposed, the Department shall issue an order which includes the:

(1) Deficiency or deficiencies on which the order was based;

(2) Amount of civil money penalty to be imposed; and

(3) Manner in which the amount of civil money penalty was calculated.

F. An order issued pursuant to §E of this regulation is void unless issued within 60 days of the inspection or reinspection at which the deficiency or deficiencies are identified.

.71 Civil Money Penalties — Amount of Penalty.

A. A civil money penalty imposed under this chapter for potential for more than minimal harm deficiencies may not exceed:

(1) $10,000 per instance; or

(2) $1,000 per day for an ongoing pattern of deficiencies until correction of the deficiencies has been verified and sustained compliance has been maintained.

B. A civil money penalty imposed under this chapter for actual harm deficiencies may not exceed:

(1) $10,000 per instance; or

(2) $5,000 per day for an ongoing pattern of deficiencies until correction of the deficiencies has been verified and sustained compliance has been maintained.

C. A civil money penalty imposed under this chapter for a serious and immediate threat may not exceed:

(1) $10,000 per instance; or

(2) $10,000 per day for an ongoing pattern of deficiencies until correction of the deficiencies has been verified and sustained compliance has been maintained.

D. In setting the amount of a civil money penalty, the Department shall consider the following factors:

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

(2) The degree of risk to the health, life, or safety of the residents of the nursing facility caused by the deficiency or deficiencies;

(3) The efforts made by, and the ability of, the nursing facility to correct the deficiency or deficiencies;

(4) Current federal guidelines for civil money penalties;

(5) Whether the amount of the proposed civil money penalty will jeopardize the financial ability of the nursing facility to continue operating as a nursing facility;

(6) A nursing facility's prior history of compliance; and

(7) Such other factors as justice may require.

.72 Civil Money Penalties — Effective Date and Duration of Penalty.

A. Per Instance Civil Money Penalty. The effective date may be as early as the date that the deficiency or deficiencies upon which the civil money penalty is based first occurred.

B. Per Day Civil Money Penalty.

(1) The daily civil money penalty starts to accrue as of the date of the visit that identifies the deficiency or deficiencies upon which the civil money penalty is based.

(2) The accrual of the daily civil money penalty ceases when correction of the deficiency or deficiencies upon which the civil money penalty was based has been verified and the facility has maintained sustained compliance.

.73 Civil Money Penalties — Payment of Penalty/Establishment of Escrow Account.

A. A civil money penalty payment is due 15 calendar days after:

(1) The time period for requesting a hearing has expired and a request for hearing was not received; or

(2) Receipt of a written request from the facility to waive its right to a hearing and reduce the amount of the civil money penalty by 40 percent provided the written request is received by the Department within 30 calendar days of the Department's order imposing the civil money penalty.

B. Within 15 days of the request for an appeal by a nursing facility, the nursing facility shall deposit the amount of the civil money penalty in an interest-bearing escrow account. If a per day civil money penalty is in effect at the time the escrow account is established, the amount owed on that date shall be deposited into the escrow account. The nursing facility shall bear any cost associated with establishing the escrow account, and the account shall be titled in the name of the nursing facility and the Maryland Department of Health as joint owners.

C. When the Secretary issues the final decision of the Department:

(1) If the decision upholds the imposition of the full civil money penalty, the escrow funds, in addition to the amount of any per day civil money penalty that has accrued after the initial deposit into the escrow account, shall be released to the Department within 15 days from the date of the decision;

(2) If the decision upholds the imposition of a civil money penalty, but reduces the amount of the civil money penalty, the amount due the Department shall be released to the Department with accrued interest within 15 days of the date of the decision and the balance will be released to the nursing facility within 15 days of the date of the decision; or

(3) If the decision reverses the imposition of the civil penalty, the escrow funds shall be released to the nursing facility with accrued interest within 15 days of the decision.

D. If a facility does not release or pay the civil money penalty to the Department after the Secretary has issued a final decision upholding the civil money penalty and after notice to the facility, the State may deduct the amount of the civil money penalty from any sum that is then or later owed by the State to the facility, pursuant to State Finance and Procurement Article, §7-222, Annotated Code of Maryland.

.74 Civil Money Penalties — Hearings.

A. A licensee aggrieved by the imposition of a civil money penalty may appeal the action by filing a request for a hearing in accordance with State Government Article, Title 10, Subtitle 2, Annotated Code of Maryland.

B. The Secretary has the burden of proof with respect to the imposition of civil money penalties.

C. The Office of Administrative Hearings shall render a decision within 10 working days of the hearing.

.75 Criminal Penalties.

A. A person maintaining or operating a nursing home without a license is guilty of a misdemeanor, and, on conviction, is liable for a fine of not more than $1,000 for the first offense and not more than $10,000 for each subsequent conviction in accordance with Health-General Article, §19-358, Annotated Code of Maryland.

B. Each day that the nursing home continues to operate without a license after the first conviction is a subsequent offense and may subject the operator to further criminal prosecution.

C. A person maintaining and operating a nursing home that is in violation of this chapter is guilty of a misdemeanor, and, on conviction, shall be fined not more than $1,000 under the authority of Health-General Article, §19-359, Annotated Code of Maryland.

D. Each day that the nursing home operates after the first conviction, without correction of the cited violation, is considered a subsequent offense and may subject the operator to further prosecution.

.76 Emergency Suspension.

A. The Secretary may immediately suspend a license on finding that the public health, safety, or welfare imperatively requires emergency action pursuant to State Government Article, §10-405(b), Annotated Code of Maryland.

B. The Department shall deliver a written notice to the nursing facility:

(1) Informing the nursing facility of the emergency suspension;

(2) Giving the reasons for the action and the regulation or regulations with which the licensee has failed to comply that forms the basis for the emergency suspension; and

(3) Notifying the nursing facility of its right to request a hearing and to be represented by counsel.

C. The filing of a hearing request does not stay the emergency action.

D. When a license is suspended by emergency action:

(1) The nursing facility shall immediately return the license to the Department; and

(2) The licensee shall notify the residents or representatives of the residents of the suspension and make every reasonable effort to assist them in making arrangements for transfer to other appropriate living arrangements.

E. In the event of an emergency suspension, the Department may assist in the relocation of residents.

F. A person aggrieved by the action of the Secretary under this regulation may appeal the Secretary's action by filing a request for a hearing in accordance with Regulation .59 of this chapter.

G. The Office of Administrative Hearings shall conduct a hearing as provided in Regulation .59 of this chapter and issue a proposed decision within 10 business days of the close of the hearing record. Exceptions may be filed by an aggrieved person pursuant to COMAR 10.01.03. The Secretary shall make a final decision pursuant to COMAR 10.01.03.

H. If the Secretary's final decision does not uphold the emergency suspension, the nursing facility may resume operation.

.77 Denial or Revocation of License.

A. Denial or Revocation of License. The Secretary, for cause shown, may notify the nursing facility of the decision to revoke or deny the nursing facility's license. The denial or revocation shall be stayed if a hearing is requested.

B. The Department shall notify the nursing facility in writing of the following:

(1) The effective date of the denial or revocation;

(2) The reason for the denial or revocation;

(3) The regulations with which the licensee has failed to comply that form the basis for the denial or revocation;

(4) That the nursing facility is entitled to a hearing if requested, and to be represented by counsel;

(5) That the nursing facility shall stop providing services on the effective date of the denial or revocation if the nursing facility does not request a hearing;

(6) That the denial or revocation shall be stayed if a hearing is requested; and

(7) That the nursing facility is required to surrender its license to the Department if the denial or revocation is upheld.

C. The licensee shall notify the residents or residents' representatives of any final denial or revocation and make every reasonable effort to assist them in making other living arrangements. The Department may assist in the relocation of residents.

D. A person aggrieved by the action of the Secretary under this regulation may appeal the Secretary's action by filing a request for a hearing in accordance with Regulation .59 of this chapter.

.78 Hearings.

A. A request for a hearing shall be filed with the Office of Administrative Hearings, with a copy to the Office of Health Care Quality of the Department, not later than 30 days after receipt of notice of the Secretary's action. This request shall include a copy of the Secretary's action.

B. A hearing requested under this chapter shall be conducted in accordance with:

(1) State Government Article, Title 10, Subtitle 2, Annotated Code of Maryland;

(2) COMAR 28.02.01; and

(3) COMAR 10.01.03.

C. The burden of proof is as provided in COMAR 10.01.03.28.

D. Unless otherwise stated in this chapter, the Office of Administrative Hearings shall issue a proposed decision within the time frames set forth in COMAR 28.02.01.

E. The aggrieved person may file exceptions as provided in COMAR 10.01.03.35.

F. A final decision by the Secretary shall be issued in accordance with COMAR 10.01.03.35.

.79 Health Care Quality Account.

A. The Department shall establish a health care quality account in the Department.

B. The health care quality account shall be funded by civil money penalties paid by nursing homes.

C. The Department shall use funds from the health care quality account to improve the quality of care in nursing facilities.

D. Expenditure of funds may include, but are not limited to the following:

(1) Funding for the establishment and operation of a demonstration project;

(2) A grant award;

(3) Relocation of residents in crisis situations;

(4) Provision of educational programs to nursing facilities, the Office of Health Care Quality, other government, professional, or advocacy agencies, and consumers; and

(5) Any other purpose that will directly improve quality of care.

E. Suggestions for the use of funds may be submitted to the Department from:

(1) Members of the public;

(2) Advocacy organizations;

(3) Government agencies;

(4) Professional organizations including trade associations;

(5) Nursing homes; and

(6) Nursing home associations.

F. Decision on Expenditure of Funds.

(1) The Department, in its sole discretion, shall decide how to spend funds from the health care quality account.

(2) The Department's decision to spend funds or not to spend funds for a specific project or purpose is not a contested case as defined in State Government Article, §10-202(d), Annotated Code of Maryland, and therefore is not subject to appeal.

.80 Financial Disclosure.

A. A licensee shall have financial resources in accordance with this regulation in order to:

(1) Satisfy obligations; and

(2) Ensure at all times the delivery of essential care and services, such as nursing, dietary services, or utilities.

B. A licensee shall notify the Secretary of significant adverse changes in financial condition which reasonably could be anticipated to adversely affect the delivery of essential care and services. These adverse changes include, but are not limited to, the following situations:

(1) The facility fails to maintain the facility's utilities or a quantity of supplies, including nursing, dietary, pharmaceutical, or other care and service supplies, sufficient to meet the needs of the residents;

(2) The facility is unable to meet its employee payroll or benefits obligations;

(3) The license holder or entity legally authorized to act on behalf of the license holder receives notice that a judgment or tax lien of at least $5,000 has been filed, recorded, or levied against the facility or any of the assets of the facility or the license holder and the judgment or tax lien is not satisfied, or an appropriate extension has not been obtained, within 30 days after receipt of the notice;

(4) A financial institution refuses to honor facility-operation-related checks or other financial instruments issued by the license holder or entity legally authorized to act on behalf of the license holder, and:

(a) The cumulative amount of the checks or financial instruments is $5,000 or more; and

(b) The checks or financial instruments are not honored or replaced to the satisfaction of the holders of the instruments within 10 working days after the holders have notified the license holder, operator, administrator, manager, or the person authorized to issue the instrument of the dishonored items;

(5) The license holder, or entity legally authorized to act on behalf of the license holder fails to make timely payments of any facility-related tax of at least $1,000, and fails to satisfy the tax within 30 working days after the date the tax becomes delinquent;

(6) The license holder, owner of 25 percent of the license holder's assets, or facility management company files a voluntary bankruptcy petition, or a creditor files an involuntary bankruptcy petition against the facility management company, license holder, or owner of 25 percent or greater of the license holder's assets;

(7) A court appoints a bankruptcy trustee for the facility;

(8) A person seeking appointment of a receiver for the facility files a petition for the appointment of a receiver for the facility in any jurisdiction;

(9) The license holder, or person legally authorized to act on behalf of the license holder is unable to meet conditions of a facility-operation-related loan or material debt covenant unless the loan or material debt covenant has been waived or cured, and that inability has led to a recall by the issuing entity; or

(10) The license holder, or entity legally authorized to act on behalf of the license holder, is delinquent on more than $5,000 of facility-related contractual obligations or vendor contracts that affect essential care and services for residents and has not cured the delinquency within 10 working days after receipt of notice from the creditor or creditors to pay the debt.

C. The license holder shall notify the Secretary in writing of a significant adverse change in its financial condition as required by §B of this regulation within 72 hours after the license holder becomes aware of, or reasonably should have become aware of, the change in its financial condition.

D. The license holder's notice required by §B of this regulation shall include a description of:

(1) The specific significant adverse change in financial condition;

(2) How the significant adverse change in financial condition affects or may affect the license holder's ability to deliver essential care and services; and

(3) The actions the license holder has taken to address the significant adverse change in financial condition.

E. The license holder shall fax, email, or hand-deliver the notice required in §B of this regulation to the Department's Office of Health Care Quality, and the notice shall be kept on file with a copy of the delivery confirmation.

F. The license holder shall provide any other information, unless prohibited under applicable laws, requested by the Office of Health Care Quality to substantiate continued compliance with the requirements of this regulation within 30 days after the request. Failure to comply with the requirements of this regulation may result in the Secretary imposing one or more sanctions, as appropriate, from Regulations .51—.58 of this chapter against the facility.

G. The information submitted pursuant to §D of this regulation is confidential and may not be disclosed without the consent of the licensee.

H. Unless disclosure of the information is otherwise prohibited by applicable law, the provisions of §G of this regulation do not apply to:

(1) The holder of a license that has been suspended or revoked; or

(2) The use of information in:

(a) An administrative proceeding initiated by the Department; or

(b) A judicial proceeding.

Administrative History

Effective date: June 30, 1978 (5:13 Md. R. 1053)

This chapter is a compilation and revision of prior regulations contained in COMAR 10.07.02, Nursing Homes—Extended Care, and COMAR 10.07.05, Intermediate Care Facilities—Long-term Care (Type A). COMAR 10.07.02 was effective January 1, 1967; amended effective March 27, 1973 and April 16, 1975 (2:8 Md. R. 565). COMAR 10.07.05 was effective July 1, 1969 and amended effective March 27, 1973.

Regulation .01B amended effective January 7, 1991 (17:26 Md. R. 2975); June 22, 1992 (19:12 Md. R. 1134); January 17, 1994 (21:1 Md. R. 33); August 15, 1994 (21:16 Md. R. 1383); June 30, 1997 (24:13 Md. R. 931); June 1, 1998 (25:11 Md. R. 821)

Regulation .01B amended as an emergency provision effective January 1, 2001 (28:4 Md. R. 414); amended permanently effective May 14, 2001 (28:9 Md. R. 885)

Regulation .01B amended effective September 16, 2002 (29:18 Md. R. 1442); March 3, 2003 (30:4 Md. R. 316); September 13, 2004 (31:18 Md. R. 1350)

Regulation .01I-1, L-1, O-1, GG-1 adopted effective January 13, 1986 (13:1 Md. R. 16)

Regulation .01GG-1, KK-1 adopted effective August 3, 1981 (8:15 Md. R. 1306)

Regulation .01II-1 adopted effective January 26, 1987 (14:2 Md. R. 128)

Regulation .01-1 adopted effective June 1, 1998 (25:11 Md. R. 821)

Regulation .01-1 amended effective January 6, 2005 (31:26 Md. R. 1862)

Regulation .02 amended effective January 14, 1988 (15:1 Md. R. 20)

Regulation .02 repealed and new Regulation .02 adopted effective May 10, 1993 (20:9 Md. R. 778)

Regulation .02 amended effective August 24, 2009 (36:17 Md. R. 1312)

Regulation .02F amended effective April 8, 1996 (23:7 Md. R. 551)

Regulation .02G adopted effective September 16, 2002 (29:18 Md. R. 1442)

Regulation .03 amended effective May 10, 1993 (20:9 Md. R. 778); August 27, 2007 (34:17 Md. R. 1507); August 24, 2009 (36:17 Md. R. 1312); August 29, 2016 (43:17 Md. R. 953)

Regulation .03A amended effective May 24, 1982 (9:10 Md. R. 1021); June 22, 1992 (19:12 Md. R. 1134)

Regulation .03B amended effective August 1, 1994 (21:15 Md. R. 1304)

Regulation .03-1 adopted effective May 10, 1993 (20:9 Md. R. 778)

Regulation .04B amended effective December 7, 1992 (19:24 Md. R. 2125)

Regulation .05 amended effective August 1, 2016 (43:15 Md. R. 864)

Regulation .05B amended effective January 17, 1994 (21:1 Md. R. 33)

Regulation .05C amended effective January 25, 1980 (7:2 Md. R. 115)

Regulation .07 amended effective January 26, 1987 (14:2 Md. R. 128); May 20, 1996 (23:10 Md. R. 731); August 24, 2009 (36:17 Md. R. 1312)

Regulation .07A amended effective August 3, 1981 (8:15 Md. R. 1306)

Regulation .07G amended effective May 24, 1982 (9:10 Md. R. 1021); January 26, 1987 (14:2 Md. R. 128); March 3, 2003 (30:4 Md. R. 316)

Regulation .07-1 adopted effective January 1, 2007 (33:26 Md. R. 1996)

Regulation .08 amended effective June 22, 1992 (19:12 Md. R. 1134)

Regulation .08A, B, D amended effective January 26, 1987 (14:2 Md. R. 128)

Regulation .08A, E amended effective January 13, 1986 (13:1 Md. R. 16)

Regulation .08-1 adopted effective September 16, 2002 (29:18 Md. R. 1442)

Regulation .09A amended effective November 8, 1982 (9:22 Md. R. 2196); January 13, 1986 (13:1 Md. R. 16); January 17, 1994 (21:1 Md. R. 33)

Regulation .09B-1 adopted effective August 3, 1981 (8:15 Md. R. 1306)

Regulation .09C, D amended effective August 24, 2009 (36:17 Md. R. 1312)

Regulation .10 amended effective January 26, 1987 (14:2 Md. R. 128); June 30, 1997 (24:13 Md. R. 931)

Regulation .10E amended effective November 8, 1982 (9:22 Md. R. 2196)

Regulation .10H amended effective May 24, 1982 (9:10 Md. R. 1021)

Regulation .10 repealed and new Regulation .10 adopted effective August 6, 2001 (28:15 Md. R. 1396)

Regulation .11 amended effective January 26, 1987 (14:2 Md. R. 128)

Regulation .11O amended effective November 8, 1982 (9:22 Md. R. 2196)

Regulation .11 repealed and new Regulation .11 adopted effective August 6, 2001 (28:15 Md. R. 1396)

Regulation .11-1 adopted effective August 6, 2001 (28:15 Md. R. 1396)

Regulation .11-2 adopted effective August 6, 2001 (28:15 Md. R. 1396)

Regulations .12, .13, .18—.21 amended effective January 13, 1986 (13:1 Md. R. 16)

Regulation .12 amended effective January 26, 1987 (14:2 Md. R. 128)

Regulation .13 amended effective January 26, 1987 (14:2 Md. R. 128)

Regulation .14-1 adopted effective August 15, 1994 (21:16 Md. R. 1383)

Regulation .14-2 adopted effective August 15, 1994 (21:16 Md. R. 1383)

Regulation .15 amended effective January 26, 1987 (14:2 Md. R. 128); September 22, 2008 (35:19 Md. R. 1716)

Regulation .15B amended effective March 16, 1992 (19:5 Md. R. 577); June 5, 1995 (22:11 Md. R. 820)

Regulation .17 amended effective January 26, 1987 (14:2 Md. R. 128)

Regulation .18B amended effective January 26, 1987 (14:2 Md. R. 128)

Regulation .19A, B amended effective January 26, 1987 (14:2 Md. R. 128)

Regulation .20 amended effective January 26, 1987 (14:2 Md. R. 128)

Regulation .21 amended effective June 1, 1998 (25:11 Md. R. 821)

Regulation .21 repealed and new Regulation .21 adopted effective January 6, 2005 (31:26 Md. R. 1862)

Regulation .21E amended effective November 8, 1982 (9:22 Md. R. 2196)

Regulation .21-1 adopted effective January 17, 1994 (21:1 Md. R. 33)

Regulation .21-1 repealed and new Regulation .21-1 adopted effective January 6, 2005 (31:26 Md. R. 1862)

Regulation .21-2 adopted effective January 6, 2005 (31:26 Md. R. 1862)

Regulation .21-3 adopted effective January 6, 2005 (31:26 Md. R. 1862)

Regulation .21-4 adopted effective January 6, 2005 (31:26 Md. R. 1862)

Regulation .22B amended effective August 3, 1981 (8:15 Md. R. 1306)

Regulation .24 repealed and new Regulation .24 adopted effective April 21, 2008 (35:8 Md. R. 805)

Regulation .26F amended and .26G—H repealed effective January 17, 1983 (10:1 Md. R. 28)

Regulation .26EE amended effective October 25, 1982 (9:21 Md. R. 2106); September 16, 2002 (29:18 Md. R. 1442)

Regulation .27A, B amended effective March 3, 2003 (30:4 Md. R. 316)

Regulation .27B amended effective January 26, 1987 (14:2 Md. R. 128)

Regulation .28 amended effective January 26, 1987 (14:2 Md. R. 128); January 17, 1994 (21:1 Md. R. 33)

Regulation .28C amended effective January 14, 1988 (15:1 Md. R. 20)

Regulation .31A amended effective September 16, 2002 (29:18 Md. R. 1442)

Regulation .32F amended effective January 17, 1994 (21:1 Md. R. 33)

Regulation .32G amended effective January 26, 1987 (14:2 Md. R. 128)

Regulation .33E amended effective January 26, 1987 (14:2 Md. R. 128)

Regulations .35—.41 adopted effective January 13, 1986 (13:1 Md. R. 16)

Regulation .35 amended effective December 16, 1996 (23:25 Md. R. 1785)

Regulation .36 amended effective December 16, 1996 (23:25 Md. R. 1785); September 16, 2002 (29:18 Md. R. 1442)

Regulation .36C amended effective March 3, 2003 (30:4 Md. R. 316)

Regulation .37 amended effective December 16, 1996 (23:25 Md. R. 1785); September 16, 2002 (29:18 Md. R. 1442)

Regulation .38 amended effective December 16, 1996 (23:25 Md. R. 1785)

Regulation .39A and B amended effective October 1, 1990 (17:19 Md. R. 2320)

Regulation .39C and D repealed effective October 1, 1990 (17:19 Md. R. 2320)

Regulation .39G amended effective June 30, 1986 (13:13 Md. R. 1491)

Regulation .40A amended effective June 30, 1986 (13:13 Md. R. 1491)

Regulations .40 and .41 recodified to Regulations .43 and .44, respectively, Appendix recodified as Regulation .40 and amended, and new Regulations .41 and .42 adopted effective October 1, 1990 (17:19 Md. R. 2320)

Regulation .41 repealed and new Regulation .41 adopted effective September 13, 2004 (31:18 Md. R. 1350)

Regulation .41A amended effective August 1, 1994 (21:15 Md. R. 1304)

Regulation .41D amended effective June 30, 1986 (13:13 Md. R. 1491)

Regulation .43C adopted effective October 1, 1990 (17:19 Md. R. 2320)

Regulations .45—.51 adopted effective January 7, 1991 (17:26 Md. R. 2975)

Regulations .45—.51 repealed as an emergency provision effective January 1, 2001 (28:4 Md. R. 414); repealed permanently effective May 14, 2001 (28:9 Md. R. 885)

Regulations .45—.60 adopted as an emergency provision effective January 1, 2001 (28:4 Md. R. 414); adopted permanently effective May 14, 2001 (28:9 Md. R. 885)

Regulation .49D amended effective September 16, 2002 (29:18 Md. R. 1442)

Regulation .54D adopted effective March 3, 2003 (30:4 Md. R. 316)

Regulation .61 adopted effective August 24, 2009 (36:17 Md. R. 1312)

Chapter revised effective June 17, 2019 (46:12 Md. R. 536)